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JOURNAL OF THE AMERICAN PODIATRY ASSOCIATION

The Official Publication of the Podiatry-Chiropody Profession

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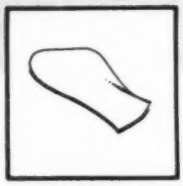

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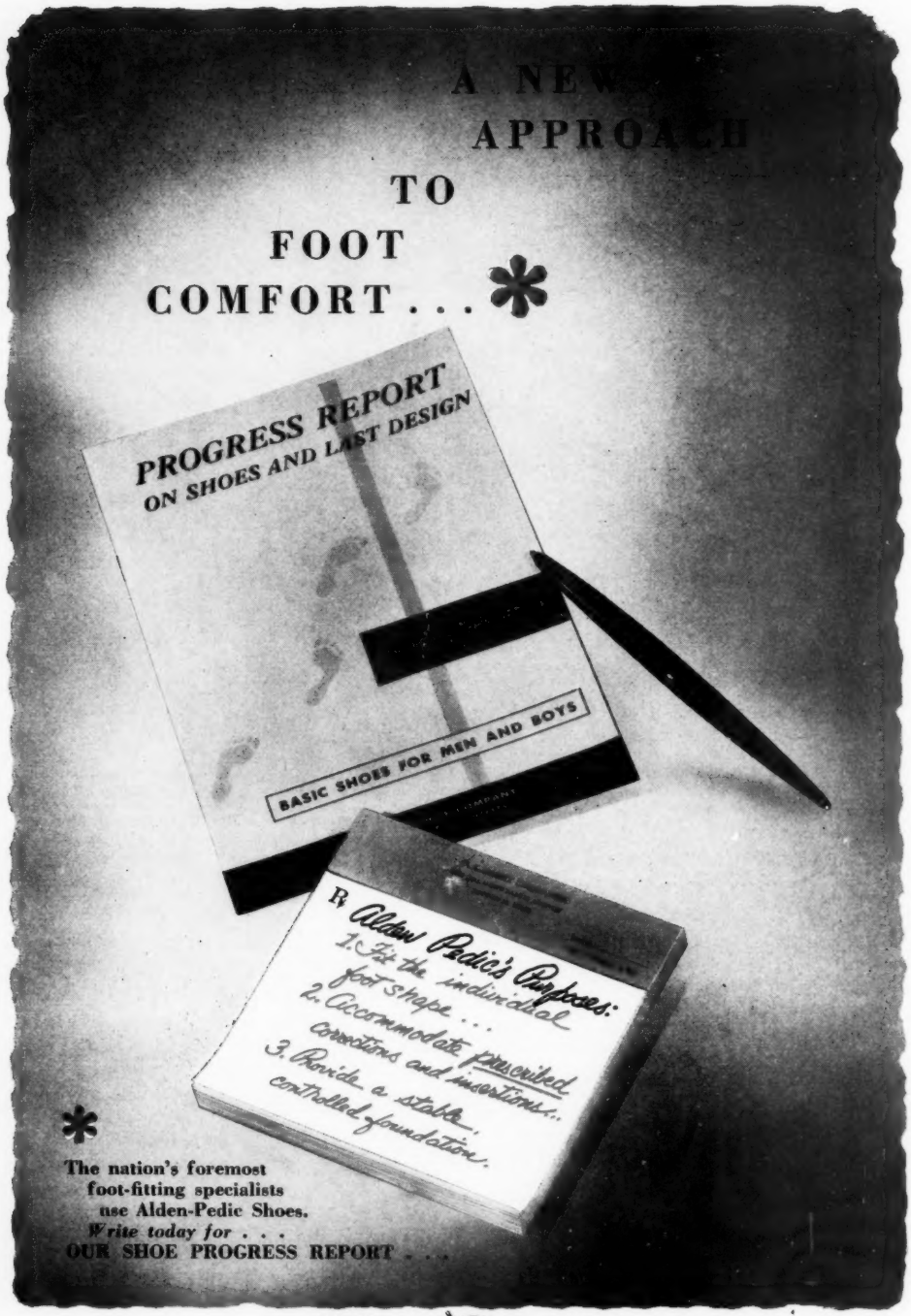
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The Iowa State Board of Chiropody Examiners will meet for examination June 5-7, 1961 at the State Office Bldg., Des Moines, Iowa. **Board Secretary:** Dr. C. C. Reinheimer, 111 W. 2nd St. South, Newton, Iowa.

Kansas

The Kansas State Board of Podiatry Examiners will meet for reciprocity and examination, June 15-16, 1961, at the K. C. Med. Center, Kansas City, Kansas. **Board President:** Dr. L. E. Krause, 1107 Williams St., Great Bend, Kansas, or Kansas Board of Podiatry Examiners, 872 New Brotherhood Bldg., Kansas City, Kansas. **Board Secretary:** F. N. Nash, M.D., 364 New Brotherhood Bldg., Kansas City, Kansas.

Kentucky

The Kentucky State Board of Chiropody meets on the third Saturday and Sunday of June and the first Saturday and Sunday of December each year. The December meeting is for re-examination only. **Board Secretary:** Dr. Chester A. Nava, 4140 Shelbyville Rd., Louisville 7, Ky.

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Louisiana State Board of Medical Examiners. **Board Secretary:** Edwin Lawson, M.D., 930 Hibernia Bank Bldg., New Orleans 12, La.

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The Maryland Board of Chiropody Examiners. **Board Secretary:** Dr. S. Jack Kleger, 408 S. Division St., Salisbury, Md.

Massachusetts

The next board meeting of the Board of Registration in Chiropody-Podiatry will be held for reciprocity, conditionally, and examination, June and December, at Room 33, State House, Boston, Mass. **Board Secretary:** Dr. Charles H. Thorner, 910 Furnace Brook Parkway, Quincy, Mass.

Michigan

The Michigan State Board of Registration in Chiropody will meet for examination in June of each year. **Board Secretary:** Dr. Albert G. Kalin, 24453 Grand River Ave., Detroit 19, Mich.

Minnesota

The Minnesota Board of Chiropody Examiners will meet for examination June 15, 16, 1961 at the State Capitol, St. Paul, Minn. **Board Secretary:** Dr. Palmer H. Goulson, 612 Southdale Medical Bldg., Minneapolis 10, Minn.

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The Mississippi State Board of Health. **Board Secretary:** Archie L. Gray, M.D., Box 1700, Jackson, Miss.

Missouri

The Missouri State Board of Chiropody will meet April 28, 1961 in Jefferson City, Mo. **Board Secretary:** Frank Fulkerson, 611 Clay St., Chillicothe, Mo.

Montana

The Montana State Board of Chiropody-Medical Examiners will meet when the need arises for reciprocity or examination at the Capitol Bldg., Helena, Mont. **Board Secretary:** Dr. L. M. Jennings, 411 First National Bank, Bozeman, Mont.

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The Nebraska State Board of Examiners in Chiropody. **Board Secretary:** Herman F. Gartner, D.S.C., First Natl. Bank Bldg., Lincoln, Nebr.

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The Nevada State Chiropody Board. **Board Secretary:** Dr. William A. Edwards, 150 No. Arlington St., Reno, **Nev.**

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The New Hampshire Board of Registration in Chiropody will meet for examination in June, 1961, at 61 Spring St., Concord N. H. **Board Secretary:** Edward W. Colby, M.D., 61 S. Spring St., Concord, N. H.

New Jersey

The New Jersey State Board of Medical Examiners meets semi-annually for examination on the third Tuesday, Wednesday, Thursday and Friday of June and October. **Board Secretary:** Royal A. Schaaf, M.D., 28 West State St., Trenton 8, N. J.

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The New Mexico State Board of Podiatry will meet for examination July 15-16, 1961. **Board Secretary:** Morris Haas, D.S.C., 121 Sycamore St., N.E., Albuquerque, N. M.

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The New York State Board of Podiatry Examiners. **Board Secretary:** James O. Hoyle, Ed.D., 23 S. Pearl St., Albany, New York.

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State Board *(Cont.)*

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Oregon

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Pennsylvania

Pennsylvania State Board of Chiropody Examiners will meet for examination July 19-20, 1961, at the Education Bldg., Harrisburg, Pa. **Board Secretary:** Dr. Jack S. Pincus, 26 N. 3rd St., Harrisburg, Pa.

Rhode Island

The Rhode Island Board of Examiners in Chiropody. **Administrator: Thomas B. Casey, 366 State Office Bldg., Providence, R. I.**

South Carolina

The South Carolina Board of Podiatry Examiners will meet for reciprocity and examination at the discretion of the Board. **Board Secretary:** Dr. James D. Hill, 122 W. Whitner St., Anderson, S. C.

South Dakota

The South Dakota State Board of Chiropody Examiners will meet at the discretion of the Board. **Board Secretary:** Viola Marr, 115 N. Main Ave., Sioux Falls, S. D.

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The Wisconsin State Board of Examiners will meet for examination July 11-12, 1961, at the Public Service Auditorium, Milwaukee, Wis. **Board Secretary:** Roy M. Cowen, 2018 E. North Ave., Milwaukee 2, Wis.

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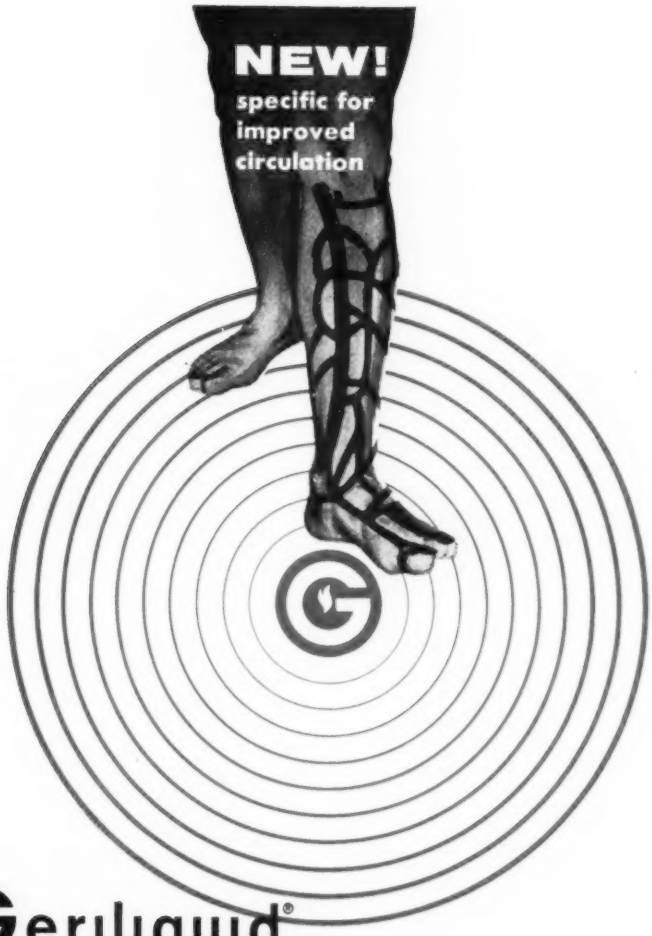

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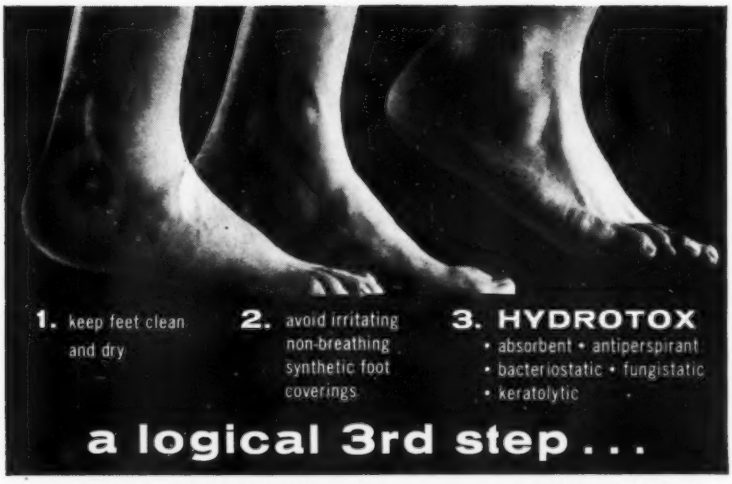
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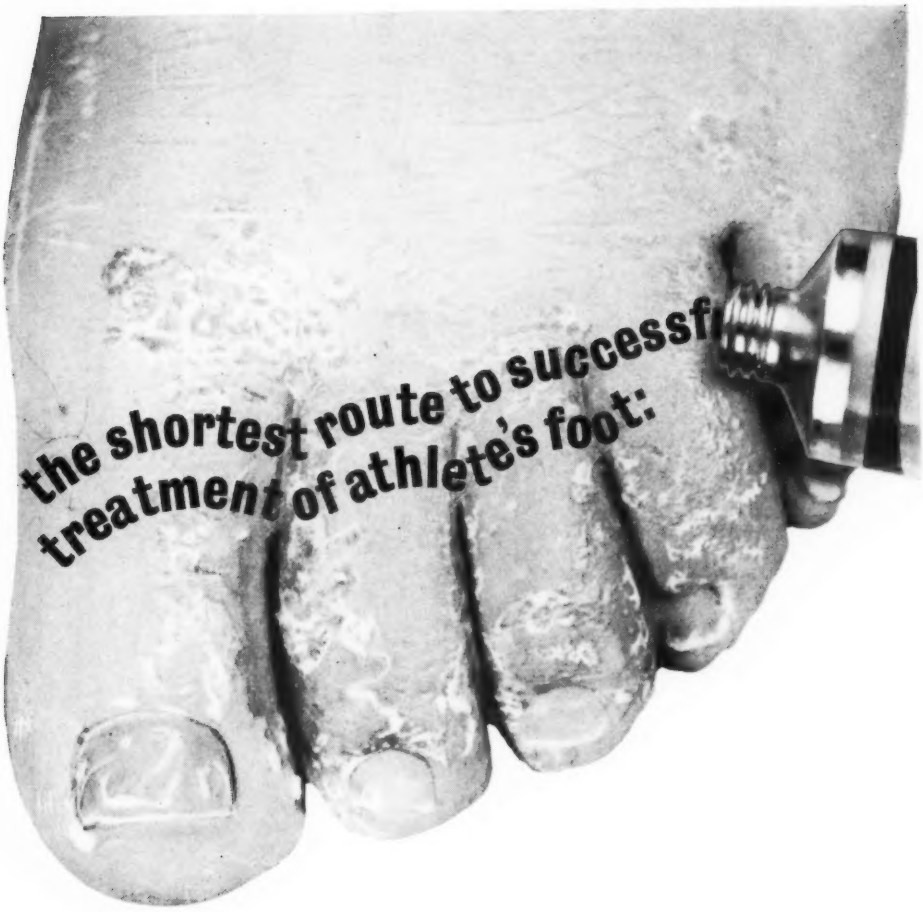

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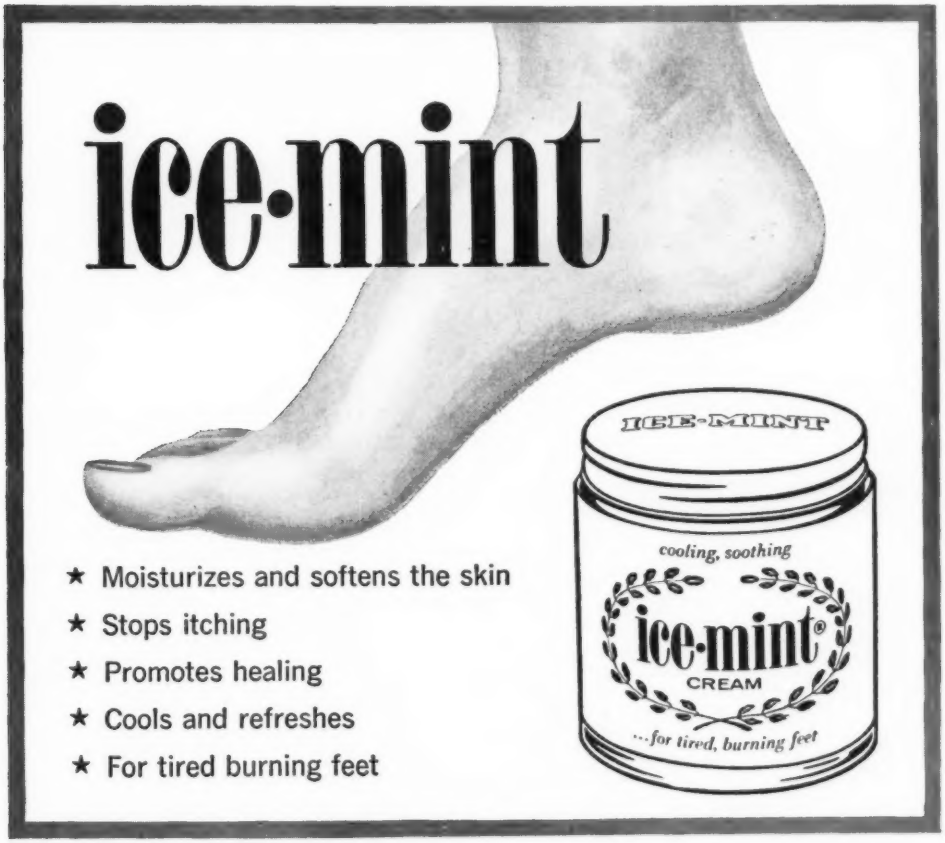

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VOLUME 51 APRIL 1961 NUMBER 4

Bone Resection in Relation to Trabecular Patterns*

Milton Henenfeld, Pod.D.
Milton H. Walkes, Pod.D.
New York, N. Y.

One of the many problems facing the surgeon is the amount of bone which is to be resected to relieve a pathologic condition. Enough bone must be removed to accomplish the purpose of the operation and yet sufficient must be left to permit proper or adequate function. This decision should not be left to chance or guesswork on the part of the surgeon but should be evaluated on physiological principles prior to surgery. This paper presents a basis for such evaluation predicated on the stress patterns which pass through the trabeculae of bones. This principle can be employed wherever resection or ostectomy is required.

All bones consist of lamellae in which calcium is deposited. These lamellae, which consist of fibrous tissue, form the trabeculae which may be seen on the X-ray film or in a skeleton. If for various reasons the calcium is either absorbed or not deposited, the trabeculae will not be visible on the roentgenogram. The lamellae, however, are still present and are capable of transmitting stresses although less adequately. The fact that in these cases the trabeculae are not visible does not mean that the bone has been destroyed. Since the lamellae are still present, calcium may be redeposited and the bone both functionally returns to, and roentgenologically appears, normal.

One of the reasons for the absorption of calcium from bone is disuse. It has been termed "atrophy of disuse" and is not always the state in any one bone, or in a series of bones in a closed or open kinetic chain. The so-called atrophy of bone, or osteoporosis, the disuse, can be the result of the discontinuance of stresses (either compression or tension) passing through a particular bone, or a particular portion of a bone. Whereas complete discontinuance of weight-bearing for a length of time will result in widespread osteoporosis, alterations of a bone so that a portion of it can no longer transmit stresses through it will result in osteoporosis of this particular section with, frequently, an increase in the trabecular pattern in the remainder of the bone still capable of transmitting such stresses. This is observed in cysts and in fractures of bone.

*Paper submitted to the William J. Stickel Annual Awards for Research in Podiatry-Chiropody for 1960. Presented at the Annual Meeting of the A.P.A. held at the Drake Hotel, Chicago, Ill., August 1960.

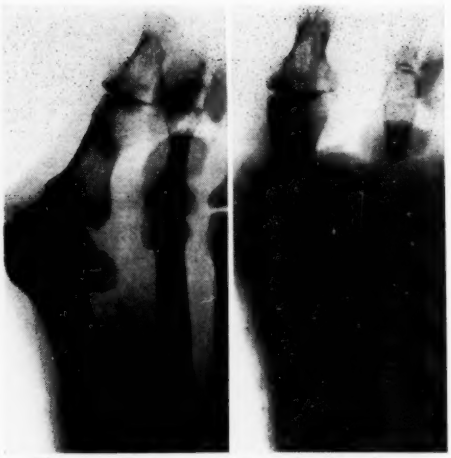

Fig. 1. Before (left) and after bone resection first metatarsal head for hallux valgus. Note that line of force can still follow the trabecular pattern following surgery (right).

The trabeculae of bone transmit the gravitational stresses of body weight as well as the tensional stresses supplied by muscle, fascia, and ligaments.

These trabeculae are known to form into patterns in response to the stresses passing through them. When these stresses change as the result of normal or pathologic alterations, the trabecular pattern is altered to conform to these changes so that function of the part may continue. In long bones these trajectoral lines of stress form in three principal axes at right angles to each other so that where the forces meet they become equalized. Thus, if the forces in any one plane are nonfunctioning, or no longer exist, changes of considerable nature will take place in the now unequalized axes which are still continuing to function.

In the foot we are mainly concerned with those forces which run forward through its length. These forces run parallel to the longitudinal axis of the metatarsals and onward into the phalanges. These carry the gravitational weightbearing stress (compression forces) of the body to the contact surface (ground). Those trabeculae which carry the tensional forces are in a horizontal plane and these forces result from ligamentous and muscular forces acting on the bone.

It is obvious, then, that a long bone, through which its trabeculae run parallel with its long axis, must also be pointed in the same direction as the force it is transmitting. Thus for proper functioning of its longitudinal axis (and the equalization of stresses) the force must be in the same direction as the trabecular pattern and therefore along the length of the bone.

We are dealing here with three factors: 1. The metatarsal bone. 2. Its trabecular pattern. 3. Lines of force passing through. Under normal conditions all three must be parallel, pointing in the same direction.

If the metatarsal should be directed at an angle instead of forward, the following may exist: 1. The metatarsal and its trajectoral pattern must remain parallel. 2. The lines of force may remain parallel if they are changed with the new direction as when the metatarsal is turned outward and the body turns outward with it. 3. The lines of force no longer coincide with the metatarsal and its trajectoral pattern as when the metatarsal is turned outward and the force is continued in a straight direction.

Therefore if the metatarsal, in the last instance, is to transmit weight forward in the direction of the line of force it can only do so through those trabeculae (if any) within the bone which are parallel at that time to the line of force. If none are available or if none can be made available this bone will not transmit weight until the situation is altered so that its trabeculae can be brought into action. If no such alteration can be brought about, osteoporosis of this bone must occur.

Thus if a metatarsal head is pointed in the direction of the forces passing through it, then its longitudinal trabeculae can transmit these forces through all the trabecular patterns existing for this purpose. If the metatarsal should be angulated 15° and the forces still directed straight ahead, then only those trabeculae which remain parallel with these forces can transmit them. The others are not being used.

In severe angulation as occurs in hallux valgus, only a minimum of trabeculae still remaining in line with these forces are employed.

Thus in a hallux valgus, depending on the degree of abduction of the metatarsals the greater the angulation the fewer trabeculae are used. Those trabeculae which are not employed will atrophy, the calcium will absorb, and no trabeculae will be observed on the roentgenogram. The only trabecular patterns seen are those which indicate the functioning parts of the metatarsal head and its opposing phalanx. The remainder are not functioning and to all intents and purposes are useless unless the metatarsal can be realigned to coincide with its line of force. Where this is impossible or not feasible or inadvisable, removal of this nonfunctioning portion of bone does not interfere in any way with the functioning of such a bone any more than leaving it intact. The portion of bone which is functioning remains the same whether that section is removed or not.

It would seem that the objection to the removal of a portion of the metatarsal head in hallux valgus because of interference with the functionability of this bone is not sustained. The bone remains with the same functioning trabeculae in either case; the amount of bone present is unimportant to this end. The removal of the nonfunctioning portion (the exostosis) provides for a better functioning part by reducing factors which result in pain and disability.

These considerations can also be applied as reason for preservation of, rather than removal of bone.

The metatarsal head permits the forces passing through the metatarsal to be transmitted into the ground by two methods. One is by direct contact with the ground surface, and the second by allowing transmission to the phalanges, and through these to the ground. When a metatarsal head is resected, there can no longer be any appreciable weight forces passing through this metatarsal ray. The stresses which were carried by these parts must now be transmitted by the other metatarsal segments which may or may not be able to carry the load. (This can be demonstrated on follow-up postoperative roentgenograms.)

It will be noted that, in those cases where metatarsal head resection has been employed, the phalanges and remaining metatarsal shaft are osteoporotic indicating no trabecular patterns of weight transmission through them. This state can also be seen where there is luxation of the proximal phalanx over its opposing metatarsal head.

The advisable procedure, it would seem to us, is to preserve this very important weight transmitting mechanism and use procedures which maintain or re-establish weight transmission patterns and still overcome the difficulties for which the operative procedure was intended.

Removal of the proximal portion of the proximal phalanx as part of a plantar condylectomy, particularly when luxation exists, does this. It maintains intact the metatarsal head, allowing continuation of the function of the metatarsal ray. With repair the body builds a fibrous bridge whose fibers form in line with the stresses passing through them and act as noncalcified lamellae.

Summary

1. The amount of bone to be resected in a pathologic condition should be evaluated on physiologic principles prior to surgery.

2. The trabecular patterns in bone represent the stress forces passing through bone.

3. When as in hallux valgus, the trabeculae of a portion of bone do not transmit stresses, this portion of bone is nonfunctioning.

4. Surgical excision of this nonfunctioning portion of bone does not interfere or alter the existing function of the remainder of the bone.

5. Resection of a metatarsal head removes the trabeculae essential for the

transmission of gravitational forces through the metatarsal segment to the ground and through the corresponding phalanx.

6. On the other hand, resection of the base of the proximal phalanx re-establishes the trabecular pattern of the metatarsal segment and its toe so that function tends to be restored.

16 E. 79th St.

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A Comparison of Surgical Approaches to Metatarsal Heads for Plantar Lesions*

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THE purpose of this paper is to present a discussion of the ablation of plantar lesions comparing direct plantar approach, dorsal approach to the plantar surface of the metatarsal head and total metatarsal head resection.

When first seen, deep tylomatous lesions occurring on the plantar aspect of the metatarsal heads are similar to other tylomatous lesions present on the foot. It is the early lesion, when carefully treated, so as not to create a massive area of necrosis and subsequent eschar formation, that will show the greatest degree of improvement and subsequent ablation. As the lesions grow older and the patient is subjected to increased intensities of therapy eschar tissue begins to appear. It would probably be far more correct to term the chronic plantar lesion a "vicious cicatrix." Once this has occurred the sloughing of this lesion cannot be expected simply by removal of pressure by means of mechanical measures such as appliances, metatarsal bars, shoes, and even complete excision of the metatarsal head or the plantar condylar processes of the metatarsal head presents failures.

One question that needed answering was whether or not the patho-mechanics would be an influencing factor in the choice of approach.

X-ray studies of fifteen cases of intractable keratoses selected at random, display a similarity in basic foot structure. The data in Table I illustrates symptoms common to all cases. The subjects varied in age from 16 to 53 years.

In each instance there was a long second metatarsal; the involved metatarsal shafts were in a position of varus on their longitudinal axis; there was a marked degree of chronic proliferative periostitis present on the medial aspect of the distal phalanx of the first digits; in each case a marked shortening of the achilles tendon had occurred, and in six cases there was an associated pes cavus; in two cases there was a marked metatarsus varus latus; hammer toes were found to occur with plantar lesions but only ten hammer toes were symptomatic and these did not correspond to the metatarsal head involved with the plantar lesion; there was a mild or severe amount of hallux valgus in ten cases and none in five cases. The five cases without hallux valgus consisted of a fifteen-year-old girl and four men between nineteen and forty-three years of age. Chronic lesions were found to occur more frequently under the second, third, and fourth metatarsal heads.

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The lesion was found to occur most often directly inferior to the metatarsal head or the metatarsophalangeal articulation. Rarely was there any identification association with the base of the proximal phalanx; and when this did occur there was a slight displacement of the soft metatarsal tissue anteriorly, precipitated by weight bearing.

In cases of long chronicity a marked amount of osteoporosis was present in the involved metatarsal head. Chronic irritation of the metatarsal head, as a result of the plantar lesion, failed to produce hypertrophy of any aspect of the metatarsal head.

The similarity of findings does not suggest that different approaches for individual cases are indicated. Apparently surgical judgment and surgeons preference is the only necessary factor in electing one of these procedures.

The dorsal approach has the following disadvantages: 1. While good, it is an indirect avenue which requires a large amount of surgical trauma in disarticulating the metatarsophalangeal joint so as to expose the plantar aspect of the metatarsal head and base of the proximal phalanx. 2. In most cases there is a great incident of dorsal luxation of the base of the proximal phalanx. 3. Complete excision of the base of the proximal phalanx results in a shortened toe which may produce an undesirable cosmetic result, especially in females. 4. In the foot the Extensor digitorum longus tendon serves as the dorsal ligament of the metatarsophalangeal articulation, and in many instances there is an adhesion between the extensor tendon and the incision which tends to produce a hammer toe deformity because of the pull of the Flexor digitorum longus tendon. 5. Inadequate delivery of the metatarsal head prevents good visualization and consequently a complete excision of the offending osseous tissue is not always performed. 6. Plantar lipomas, fibrolipomas, and bursae present inferiorly to the Flexor digitorum longus tendon are not visible and may be completely missed or not totally excised.

Complete excision of the metatarsal head presents the following disadvantages: 1. Complete excision of the metatarsal head is a complete procedure but in most cases a complete metatarsal head resection is very deceptive because it leads to complete resolution of any noncicatrical plantar lesion, but a lesion will be found to occur at a future date on the adjacent metatarsal heads. 2. The toe involved will be markedly shortened and invariably rather flail. 3. The digits will tend to be forced dorsally by the adjacent toes which poses a cosmetic and shoe fitting problem. An advantage is that postoperatively, the skin incision will coaptate easily and a lesser degree of postoperative discomfort exists as far as immediate ambulation is concerned because no surgically traumatized osseous surface remains to transmit weight.

With the plantar approach: 1. There is complete excision of the cutaneous lesion whether the offending lesion is composed of verrucous, tylomatous, or cicatrical tissue. 2. If a foreign subcutaneous mass is present it may be excised directly and completely. 3. The thickened dense plantar ligament may be excised directly and completely. 4. The roughened plantar aspect of the metatarsal head and/or the base of the proximal phalanx is exposed without producing a disarticulation. The normal anatomical relationship of this joint is observable in all instances thus facilitating an easier and more complete excision of the offending osseous tissue. 5. By approaching the problem surgically from the plantar aspect the surgeon can completely excise the cutaneous lesion; and if there is the slightest doubt as to whether osseous involvement was present from film studies made, the joint capsule can be opened directly and digital palpation will reveal the presence of a sharp rough osseous surface. If an osseous irregularity is present it may then be excised. 6. There is only a slight possibility of producing a disarticulated phalanx because the collateral ligaments and the peripheral margins of the joint capsule are never incised. 7. There is no chance of

producing a fibrous adhesion of the extensor tendon as there is in the dorsal approach. 8. The hairline eschar resulting from the plantar incision is rarely disabling as is an eschar resulting from electrodesiccation or excessive roentgen radiation.

Summary

In this paper three procedures for obliterating plantar lesions have been considered. Two procedures describe approaches from the dorsal aspect. The third, the plantar approach is most effective inasmuch as it is direct.

Before any procedure is considered each case should be carefully evaluated from mechanical and dermatologic points of view. Existing mechanical problems should be treated in an adequate fashion before surgery as there is the possibility of alleviation of symptoms without resorting to surgery. Skin lines, folds, and planes should be studied so as to elect a line of incision which produces a hairline scar.

420 E. Frank St.

Joplin's Sling Operation in Adolescent Hallux Valgus

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PERUSING the world literature on hallux valgus is a formidable task but on any attempt to do so, one is struck firstly with the very large numbers of different operations that have been devised for the condition, and secondly with the paucity of second reports on the effectiveness of any particular procedure. From this latter stricture one must of course exclude the "arthroplasties" described by W. L. Keller in 1904 [6], by C. H. Mayo in 1908 [7] and the operation of arthrodesis of the first metatarsophalangeal joint, all of which have been very fully and widely documented.

TABLE I

Colchester School Clinic

Number of new cases attending 1948-1957	556
Number attending because of hallux valgus	47 (8.5%)

Furthermore, it is noticeable that when second reports are published, they are nearly always from the same pen, or at least the same clinic that was responsible for the first paper. It is felt, therefore, that the experiences in two clinics in England with an operation recently described in the United States would be worth recording.

Hallux valgus in childhood and adolescence is a common problem in the United Kingdom for which so far there has been no certain method of correction. Some idea of its incidence may be had from a review of the attendance at a school children's Orthopaedic Clinic in Colchester over the period 1948-1957 (Table I). Its frequency compared with that of other common childhood conditions is shown in Table II. Not all the deformities seen are severe enough to require operative treatment of course, but it has been found that about one tenth of the children seen undergo operation either because of the deformity or because of the presence of associated

TABLE II

Analysis of 100 unselected consecutive cases attending the school clinic in 1956-1957.

Knock knee	17
Flat foot	11
Other foot deformity (except H.V.)	11
Torticollis	8
Scoliosis	8
Hallux Valgus	8
Postural deformity	7
Bow leg	5
Spastic paralysis	3
Poliomyelitis	3
Miscellaneous	19

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Fig. 1—Feet of a 10-year-old girl with severe hallux valgus (Case 19).

pain (Fig 1). Before 1952 the operation performed usually was either simple exostectomy with capsule reefing on the inner side of the joint, or occasionally the McBride operation[8]. In 1950, however, a new technique was described by Joplin[5] which purported to correct hallux valgus and also the frequently associated splayfoot deformity by excising the exostosis, transplanting the tendon of Adductor hallucis through the metatarsal head to the medial side of the capsule of the first metatarsophalangeal joint, and detaching the tendon of the Extensor digiti minimi and bringing it across the sole of the foot to form a new and tighter "transverse metatarsal ligament." In 1952, therefore, it was decided to try this new procedure in adolescent patients with hallux valgus severe enough to need operation.

During the period 1952-1957 21 child or adolescent patients underwent the sling operation at Black Notley Hospital and another four adolescents at the London Hospital. These form the basis of the series reviewed here. At the same time another 14 adult patients were operated on, using the same technique. Altogether 20 adolescents have been followed up out of the original 28. Three were traced but not examined personally and have therefore been excluded from the results. Twelve of the patients followed up had had both feet operated on, making 32 feet in all.

Only two of the patients were boys, the sex incidence agreeing with other authors

TABLE III

Case No. & sex	Length of follow up	Age at op.	Post operative stiffness	Pain		Shoe difficulty		Shape of ant. metatarsal arch	Result	
				Pre-op.	Post-op.	Pre-op.	Post-op.		Subj.	Obj.
1. F	5 y. 7 m.	19	+	+	None	+	−	Good	G	F
2. F	5 y. 1 m.	15	−	−	None	+	−	Good	G	G
3. F	4 y. 7 m.	18	−	+	Slight	+	−	Good	G	G
4. M	4 y. 2 m.	16	+	−	None	+	+	Good	G	F
5. F	4 y. 0 m.	10	+	−	None	+	−	Good	F	F
6. F	4 y. 1 m.	14	+	+	None	+	−	Good	G	F
7. F	3 y. 6 m.	14	−	+	Slight	+	−	Good	G	G
8. F	3 y. 6 m.	17	+	−	Slight	+	−	Good	P	P
9. F	3 y. 3 m.	15	+	+	Slight	−	−	Good	G	F
10. F	3 y. 3 m.	12	+	+	Worse	+	+	Flat	P	P
11. F	2 y. 5 m.	14	+	+	None	+	−	Flat	G	F
12. F	2 y. 1 m.	16	+	−	Slight	+	−	Good	P	F
13. F	1 y. 10 m.	19	−	−	None	−	−	Good	G	F
14. F	1 y. 8 m.	11	−	+	None	+	−	Good	G	G
15. F	1 y. 3 m.	20	+	+	None	+	−	Good	G	F
16. F	1 y. 2 m.	14	+	−	None	−	−	Good	G	F
17. M	1 y. 1 m.	15	−	+	Unchd.	+	+	Flat	F	F
18. F	9 m.	12	−	−	None	−	−	Good	G	F
19. F	7 m.	11	−	−	None	+	+	Good	P	P
20. F	6 m.	16	+	+	Slight	−	−	Good	G	F

(Cleveland and Winant [3]). The age at operation varied from 10 years to 20 years with an average of 15 years. The time elapsed between operation and review varied from 6 months to 5 years and 7 months with an average of 2 years and 9 months (Table III).

In all cases the operation was performed in its modified form (Campbell's Operative Orthopaedics [2]). Eight of the earlier cases had the feet immobilized in plaster splints after operation for 2 to 3 weeks. The others had strapping splints only.

Results

The results have been assessed as either good, fair or poor and both a subjective and an objective rating have been obtained. The latter follows the specifications laid down by McBride [8]. A good result is obtained when recovery time is short, the corrected alignment of the great toe is normal, pain has been relieved and joint action has not been materially affected. Table IV shows the results both subjective and objective. It will be seen that although in both gradings there is an equal number of poor results—just over one-fifth of the total — there is a distinct difference between the two groups of the numbers of good and fair results. This difference is almost entirely due to the presence of limitation of movement of the metatarsophalangeal joints of the great toe, noted on examination as an adverse factor in grading the end result objectively, but apparently giving rise to no subjective disability except in one patient who complained of the stiffness. In all the others, when such stiffness was present, it did not appear to detract from the value of the operation as far as the patient was concerned.

TABLE IV
Results of Sling Operation in Adolescent Hallux Valgus

	Good	Fair	Poor
Subjective	20	5	7
Objective	5	20	7

M.P. Joint Movement

No figures have been found in the literature defining what the normal range of movement in the first metatarsophalangeal joint is. However, it has been suggested that the minimum ranges acceptable even after an arthoplasty (Cleveland and Winant [3]) are 30° dorsiflexion and 10° plantar flexion, and these figures have been taken as "normal" in this review. Twelve feet were found to have less than 10° plantar flexion in the series, and another five less than 30° dorsiflexion.

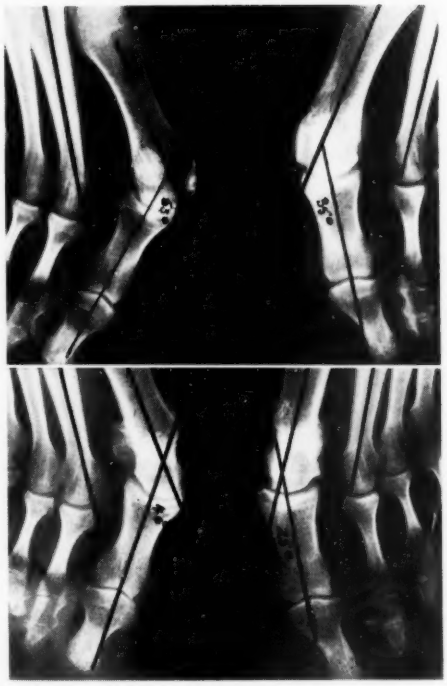

Fig. 2—Pre- and postoperative X-rays of Case 8 to show typical improvement in hallux valgus angle.

Pain

The effect of the operation in relieving pain was generally satisfactory. Eleven patients had complained of pain before operation, and of these nine were either completely relieved or at least much improved. The remaining two had as much or even more pain after operation. Furthermore, two patients complained of pain coming on for the first time after the operation, but in each case the pain was described as "slight" only.

Fig. 3—Pre- and postoperative X-rays of Case 7 to show marked improvement of hallux valgus angle with little change in the intermetatarsal angle.

Deformity

In general the operation has been successful in reducing the degree of valgus displacement of the great toe. Twenty-four feet were improved, fifteen to a normal position. Six were substantially unchanged and in two feet the position was worse at review, one with an increased degree of valgus and one with a varus deformity of the great toe from overcorrection. It must be remembered, however, that at operation all the toes were corrected to a normal position (i.e. 10° or less of valgus) and therefore 16 relapsed at some time after operation, the relapse usually commencing soon after removal of the splints and increasing slowly with time. The one toe which went into varus was overcorrected at operation and changed little thereafter.

In 25 feet on which a pre- and postoperative clinical assessment of the hallux valgus angle was made it was found that the average improvement was from approximately 32° to 15°. In the 11 feet for which pre- and postoperative radiographs were available, the average improvement was from 37° to 27° (Fig. 3). As in general only the more markedly deformed feet had preoperative radiographs taken, the apparent discrepancy is understandable. Furthermore, the bulge of the exostosis increases the apparent degree of hallux valgus and hence its removal magnifies the improvement measured clinically as compared to the radiographical change (Table V).

Splayfoot

In order to assess the effect of the operation on the splayfoot deformity, the intermetatarsal angle (Hardy and Clapham [4]) was measured in those cases in which pre- and postoperative radiographs were available. In all cases but one the angle was reduced, the average being from 10.9° to 8.2°, an improvement of about 25 percent (Figs. 3 and 4). The angles are, however, so small that possible errors in measurement must be taken into account to reduce their value as a guide to the success of the operation. A further attempt therefore at clinical assessment was made by examining the shape of the anterior metatarsal arch postoperatively. In five feet only was it noted to be flattened but in no case had callosi-

Fig. 4—Pre- and postoperative X-rays of Case 4 to show marked improvement in the intermetatarsal angle but little change in the hallux valgus angle.

TABLE V

Case No.	Clinical Degree of Valgus		Radiological degree of valgus		Intermetatarsal angle		Comments
	Pre-op	Post-op	Pre-op	Post-op	Pre-op	Post-op	
1	20	0	28	14	10	4	
2	30	5	—	14	—	10	
	40	20	—	31	—	11	
3	30	10	31	10	11	6	
	30	30	31	33	11	10	
4	15	5	43	37	12	11	
	15	30	50	45	18	12	Fig. 4
5	Marked	20	—	33	—	10	
		0	—	12	—	8	
6	30	5	28	34	8	10	Demonstrating well inaccuracy of clinical assessment of degree of valgus.
7	45	4	—	28	—	9	
	45	5	—	9	—	4	
8	Gross	45	53	40	10	8	Fig. 2
	Moderate	15	35	25	9	5	
9	Well Marked	0° varus	—	25°	—	15	Fig. 5
	" "	5°	—	— 5°	—	12	
10	15	5	—	31	—	12	Again shows how inaccurate clinical measurement may be
	15	10	—	37	—	12	
11	20	20	—	43	—	7	
12	10	10	—	30	—	10	
13	30	20	—	28	—	11	
	30	30	—	31	—	19	
14	45	10	40	17	7	4	
15	30	0	—	8	—	5	Prolonged sepsis
	30	0	—	7	—	6	
16	Severe	15	—	34	—	10	
17	45	20	32	18	12	12	Fig. 3
18	30	20	32	20	11	8	Fig. 6
19	45	45	—	—	—	—	Immediate total relapse
	60	60	—	—	—	—	
20	45	5	—	30	—	10	
	45	20	—	33	—	7	

ties developed. The other 27 forefeet were narrow with well-formed transverse arches.

Shoe Fitting

Sixteen of the patients had found difficulty in obtaining comfortable shoes before operation because of the deformity, but only five still had trouble afterwards.

Recovery Time

The patients were normally allowed weight-bearing on the operated foot 3 weeks after the operation. Postoperative swelling and discomfort usually subsided quickly, although in 4 patients there was persistent swelling of the forefoot at review, in 2 of these over 3 years after operation. In one case there was serious delay in wound healing because of an infection which discharged for 6 months before settling completely. The end result in this case was classified both by the patient and the observer as fair.

Complications

There were no systemic complications of the operation. Infection complicated the immediate postoperative period in 6 patients of the 20, but in only one was the infection of any magnitude or important in the final result. Toe clawing, commencing in the postoperative period, was noted in two patients. In one, this was associated with marked overcorrection of the deformity, the great toe finally being in 5° varus (Fig. 5) with a flexion deformity at the interphalangeal joint and an overlying cal-

losity. In the other case the toe clawing was associated with stiffness of the great toe and abnormal shoe wear on the outer border of the heels. This girl had been noted to have "valgus feet" before the operation, but the abnormal shoe wear developed only afterwards. Movement in the metatarsophalangeal joint was limited to 10° dorsiflexion to 45° dorsiflexion. It is

Fig. 5—A bad result with varus deformity of great toe, toe clawing and callosities. (Case 9).

probable that the loss of plantar flexion at the metatarsophalangeal joint had aggravated the pronation of the feet and thus increased the abnormal pressure on the shoes.

Discussion

On a subjective assessment the results of the Joplin sling operation in adolescent hallux valgus appears to be satisfactory in approximately four-fifths of cases. Two of the patients who had only one foot operated on originally, have now developed deformity on the other side and have asked for the second foot to be done. This compares favorably with the results of other "conservative" operations, for example, metatarsal osteotomy (Bonney and McNab[1]).

Objectively the results are not so satisfactory. Although the bunion is removed and correction of the deformity and narrowing of the forefoot are obtained on most cases, much of the latter is doubtless due to removal of the bunion itself and not to any significant change in the relationship of the metatarsal shafts (Fig. 6), as the alteration on the intermetatarsal angle is so slight. There is, however, a high proportion of feet in which there is a resultant stiffness of the great toe. Joplin[5] mentions this as a possible complication and suggests that it can be avoided by a careful operative technique, but this has not proved so in this series. The cause of this metatarsophalangeal joint stiffness must be in the fibrosis and contraction which follow the insertion of the Adductor hallucis tendon into the medial capsule and the tethering of the abductor tendon, the tendon of Extensor hallucis longus and that of Extensor digiti minimi on the dorsum of the first metatarsal neck. The limitation of toe movement has so far caused symptoms directly in only one foot, and possibly indirectly in one other case, but it is felt that it is likely to give rise to trouble in later life. The mobility of the foot as a whole has not been affected but clawing of the toes has appeared and caused symptoms in two pa-

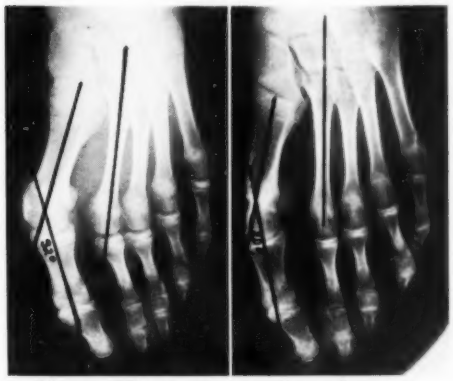

Fig. 6—These X-rays show how removal of the exostosis apparently narrows the foot with little change in the intermetatarsal angle (Case 18).

tients since the operation. This is possibly due to damage to the interosseous muscles while the new "transverse ligament" is passed blindly across the sole of the foot.

It would appear therefore that to gain only a possible slight improvement in the

degree of metatarsus primus varus, this operation is too severe a procedure with too high an incidence of complication to be acceptable. It must therefore remain of doubtful value in the treatment of hallux valgus in the adolescent.

Summary

1. In 20 adolescent patients with hallux valgus, Joplin's sling operation has been performed on 32 feet.

2. Subjectively the result was good in 20 feet, objectively in only 5, the difference being due to the presence of symptomless stiffness of the great toe in nearly all cases.

3. Because of this, the operation is considered to be of doubtful value in the treatment of adolescent hallux valgus.

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Medical Responsibilities and the Podiatrist in Hospitals

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THE purpose of this paper is to emphasize to the podiatrist the necessity for medical responsibilities especially in the performance of foot surgery. A survey in the field of podiatric surgery reveals a phase much neglected on the part of medicine. Within the past few years, many podiatrists have qualified for affiliate staff admittance to various hospitals. In many cases he has been able to perform surgery in accredited hospitals under the direction of the Department of Surgery. The number of surgical procedures performed in hospitals has increased due, in part, to insurance language to wit: "surgery reimbursement will be payable if surgery is performed within a hospital."

In most hospitals, elective or minor surgical procedures tend to be lost in the mass of the more dramatic major surgery. Therefore, it behooves the podiatric surgeon to prepare and familiarize himself with hospital protocol.

Surveys also reveal an increase of foot surgery performed under general anesthesia administered by an anesthesiologist. The podiatrist must fully comprehend the limitations and the dangers involved during and following its use. Certain information is imperative from patients undergoing general anesthesia. Questions regarding state of health with special stress on cardiac and cerebral symptoms should be noted. Further information should include questions relating to recent upper respiratory infections, recent surgery or any complications along with a history of previous anesthesia.

In surgery the use of anesthesia serves a twofold purpose: (1) It relieves pain. (2) It produces muscular relaxation. It accomplishes these effects by producing loss of

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consciousness and increasing depression of the central nervous system. Local anesthesias produce their effects by interfering with nerve conduction.

Surgical procedures such as those performed by podiatrists require little, if any, muscular relaxation and may be performed easily with the requisite degree of relief from pain.

In most cases of elective surgery, the physician has a complete picture of the patient's *general physical status* for weeks or even months in advance. A complete physical examination is necessary to determine his ability to withstand the effects of surgery and anesthesia. Frequently, laboratory tests, electrocardiogram, chest X-ray and other tests have been performed and studied. When indicated, patients receive a course of medical therapy or weight reduction preparatory to surgery.

Many podiatry patients, however, have not had the benefit of thorough physical evaluation, nor have they been cleared for surgery until the time of admission to the hospital on the evening or morning prior to surgery. Considerable time and effort have been expended to make the necessary arrangements with the employer, the patient, the family, the surgeon, the surgical assistant, the anesthetist, laboratory and nursing staff, operating room personnel, and the hospital administration. By this time it is a little late in the day to discover that the patient is not properly prepared physically or emotionally for surgery.

A few of the problems that have arisen in certain cases are illustrated as follows:

Patient A: Female, age 14, unmarried. Examination on the eve of surgery reveals pregnancy in the first trimester. Case cancelled.

Patient B: Middle-aged female. Develops gross cardiac arrhythmia on operating table prior to administration of anesthetic. Case cancelled.

Patient C: Young female had severe respiratory infection several days prior to surgery of which the doctor was aware. No follow-up physical was made. Patient admitted, still symptomatic, with signs of respiratory infection. Since there was some question of pneumonia, patient was discharged to her personal physician. Case cancelled.

Patient D: Female, five feet two, eyes of blue, packs 242 pounds on a small frame. History of orthopnea, dyspnea on exertion and fleeting chest pains. Question of early heart failure and/or coronary insufficiency. Case indicates patient is much too obese for correction of contracted toes. Surgery delay in A.M. until cardiologist can perform physical and EKG evaluation.

Patient E: Young married female with severe anxiety neurosis. Sees doctor in office at 6:30 P.M. and told that superficial lesion on foot (papilloma) should be removed "as soon as possible." Admitted to hospital at 8:00 P.M., same day, in severe state of panic, with cold, clammy skin and nausea, tachycardia, and hypotension. Patient vomited premedication that evening, and after a terrifying night, vomited morning premedication. Then she fainted. Diagnosis: neurogenic shock, superimposed upon acute anxiety state; superimposed on chronic anxiety neurosis. Case cancelled.

Of course, podiatrists do not have a monopoly on cases that have to be cancelled at the last minute. Any patient can develop fever, chills, cough, diarrhea, etc. after they have been evaluated and cleared for surgery. Frequently, a phone call the day before admission will bring to light an incipient problem. Last-minute cancellation happens to the best of surgeons.

The fact that almost any patient can withstand surgery and anesthesia of any kind is a tribute to the durability of the human organism and to modern anesthetic techniques. There are very few conditions where surgery is absolutely contraindicated; but there are numerous situations in which the prudent physician will defer surgery until the patient is adequately evaluated and in the optimum condition.

Recent acute disorders such as colds, flu, gastroenteritis, alcoholic binges, hepatitis, urinary infections, etc. may not carry a great mortality, but will have a high incidence of postoperative morbidity. Usually these patients are not completely clear for

weeks or months after the symptoms have subsided.

Chronic respiratory disorders such as bronchitis, bronchiectasis, pulmonary emphysema, and asthma may require several weeks of preparation with deep breathing and coughing exercises, postural drainage, aerosol inhalations, expectorant medication, bronchodilators, and broad spectrum antibiotics.

Patients with extreme obesity—particularly those with functional disability—die with great ease during and immediately after surgery. Also, postoperative morbidity rates are high. Only the most extenuating circumstances should prompt surgeons and anesthesiologists to tackle a mountain of fat.

Thorough preparation and coordination with the parties involved must be made with patients who have severe respiratory, circulatory, neurologic, metabolic, or other systemic disorders. In such cases the mortality and morbidity risks must be plotted against the severity of the disability and the amount of functional and symptomatic benefits to be derived from surgery.

It is recommended that the Guedel Classification of Physical Status be used as a reference point for all podiatry patients.

Class I: An individual with no organic disease or with *localized* disease which causes no systemic disturbance.

Includes foot deformities, localized infection without systemic manifestations, etc.

Class II: An individual with moderate systemic disturbance.

Includes mild diabetes (controlled), moderate anemia (10-12 Gm Hb), moderate chronic respiratory disorders, Cardiac Functional Capacity I or IIa, infection with fever and/or angiitis, moderate hypertension (140-180 systolic or over 100 diastolic).

Class III: An individual with severe systemic disturbance.

Includes advanced renal or hepatic disease; history of strokes or coronary insufficiency; severe bronchiectasis, emphysema, or asthma; severe anemia (below 10 Gm Hg).

Class IV: An individual suffering from systemic disorders which are an imminent threat to life.

Class V: All patients operated upon for *emergency* conditions who would otherwise be in Classes 1 or 2.

Class VI: All patients operated upon for *emergency* conditions who would otherwise be in Classes 3 or 4.

Class VII: All patients who are moribund.

In many instances the anesthesiologist performs the preoperative evaluation of podiatry patients as an accommodation to the surgeon and patient. That this is unsatisfactory can be illustrated by any number of cases.

In view of the moral, professional, and legal responsibilities of the anesthesiologist, it is recommended that the following procedures be adhered to for all podiatry surgical cases:

1. A history and physical exam will be performed by an M.D. *prior* to scheduling of *all* cases for surgery. (It is preferable that the examiner be a member of the staff, but this is not mandatory.)
2. Patients in Class IV, VI, or VII should not be accepted for surgery.
3. Patients in Class II, III, and V will be admitted under the joint names of the podiatrist and an M.D. who is a member of the hospital staff or is acceptable to the staff (Temporary Courtesy Privilege).
4. An M.D. staff member with surgical privileges will assist in surgery for all patients in Class III and V.
5. Class I patients are exempt from the provisions of paragraphs 3 and 4 (above).

Podiatry "physicians" need not be reminded that their acceptance and integration with other physicians will be in direct proportion to the degree with which they adopt standards of excellence commensurate with or superior to those of other physicians. Patients and other physicians can only respect you *more* for prudent preparation and intelligent use of existing consultative services and diagnostic facilities.

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Foot Imbalance Following Foot Surgery*

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THIS paper is an attempt to record some of the reasons why surgery on the foot is followed by foot imbalance and often intractable pain. This is not to imply criticism either against foot surgery in general or upon the surgeon in particular, but to ascertain why, despite meticulous and skilled surgery, foot disability with pain still developed.

The podiatrist sees many feet that have been operated upon. I shall divide these cases into three general categories, those that have had surgery of the rearfoot, those of the midtarsal or midfoot region and those of the forefoot. No attempt is made to cover all types of foot surgery.

Rearfoot Surgery Resulting in Imbalance

The rearfoot provides stability to the ankle joint, initially receives and absorbs the entire body weight and counter-shock of transmitting the body weight to the ground. Thus in examining any foot for rearfoot disability, the gliding mechanism of the Achilles tendon, the degree and extent of motion in the ankle joint and the nature and quality of the fat pad that serves to protect the heel bone in weight transmission and shock reception, serve as essential criteria in determining reasons for failure, as well as indicating treatment.

The cases selected have been chosen because I feel they represent the commonest of the major failures, often encountered in our daily practice. By and large, surgery has been done to stabilize an ankle joint as a result of deformity or infection, as the result of trauma and occasionally as a consequence of serious circulatory impairment or gangrene.

Case 1—Gliding Mechanism of the Achilles Tendon[1,2]

In this particular type of injury, the patient has sustained trauma that has necessitated repair at the insertion of the Achilles tendon. This is often associated with a compound fracture of the os calcis, e.g., a workman who falls off a ladder from a height, landing on concrete, striking his heel, producing an impaction injury. The surgeon, in order to preserve the gliding mechanism of the heel cord has been obliged to trim and scrape the posterior border of the calcaneum and in so doing remove some of the plantar fat pad. Thus despite a cosmetically fine looking foot, good sliding action of the Achilles tendon, there is intractable pain due to loss of the plantar fat pad in the affected heel. If the height of the heels is compared from a point on the tip of the navicular tuberosity to the floor, this difference becomes readily apparent. Treatment then will resolve itself around providing the patient with some sort of removable heel lift which will restore balance and serves as a shock absorber. My experience has been that this heel lift should also be inclined to one side, tissue usually having been removed from the plantar surface of only one side of the heel and not both.

Case 2—Amputation at or Below the Ankle Joint

Amputation has been performed because of threatening gangrene, thrombus or infarction, ascending infection or malignancy. If the surgeon has arthrodesed the remnants of the ankle joint, there is nothing that the podiatrist can add to the service rendered by the bracemaker. However, if there is some motion, no matter how little, in the ankle joint, then this is a matter of prime concern for a podiatrist. If there is no motion obtainable, then a simple shortage boot will suffice. However, any degree of motion will result in chafing of the skin

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Fig. 1

at the tip, with ulceration, pain, oozing, etc. These cases are rare but three cases have been reported in our literature,[3,4] one by myself.[5] In order to preserve and encourage maximum motion, stimulate circulation and promote healing, a moccasin type of prosthetic is fitted into a modified oxford fitted with a collarette and a heel raise. This compensates for the shortage, permits ankle motion, provides adequate stability, and weighs no more than the conventional shortage boot. It has an advantage in that by wearing ankle socks, the collarette is hidden and both feet appear identical. The standard amputation boot is very obvious and frequently adds a psychological insult.

Case 3—Triple Arthrodesis

This type of surgery is usually performed to stabilize the subtalus joint to overcome either a congenital or acquired deformity. It may or may not involve the placing of metal staples or clips to minimize motion between the bones involved. Precisely why some of these patients develop disability and pain after undergoing such major surgery is a puzzle to this writer. Each case that I have seen has usually exhibited a minimum of scar tissue, excellent cosmetic result, a solid rearfoot; yet, despite this, the patient seems to be having trouble.

In the case presented herein, a young man had this type of surgery performed for poliomyelitis contracted 6 years previously, with insertion of metal staples. (Fig. 1.) Despite apparently excellent surgery this patient reported with chronic pain in the plantar fascia of the affected foot. Insertion of a simple felt medial flange into his footwear relieved the condition. It seems that this type of postoperative patient can tolerate only a minimum of padding, otherwise there is too much stress on the recently fused bones. On the other hand, the pain is due to the interference with weight transmission and shock absorption of the heel from limitation of ankle motion. Hence the padding must be a compromise between reducing the function of the heel with that of stabilizing the ankle joint.

Midfoot or Midtarsal Surgery Resulting in Imbalance

The bones of the midfoot region articulate with one another at inclined angles or planes to form a bony wedge[6] which serve to cushion the shock of counterpressure from the ground being passed from rearfoot to forefoot. Because these bones have inclined planes they also pass some of this shock and weight laterally to the ground via the tuberosity of the fifth metatarsal and cuboid. Generally speaking the commonest surgery involving this region is for correction of a talipes deformity of one type or another.

Case 4—Surgery Disturbing Bony Wedge Set at an Inclined Plane

In this case, a young child has undergone two operations and still walks markedly adducted. As a result of previous surgery to the Achilles tendon as well as osteotomy to the cuboid, a combination of shoe and appliance therapy is indicated. By adding a lateral flange to the heel of the shoe of the affected foot, together with a reverse Whitman appliance, gait was readily controlled and irritation over the cuboid eliminated.

The lateral flanging of the shoe-heel provides a new center for weight reception and transmission, which, when coupled with a reverse Whitman serves to restore the midtarsal bones in their proper relationship. The midfoot thus once again serving as a shock absorber and reducer despite the fact

that their inclined planes have been altered by surgery. It seems that whenever this relationship is disturbed, disability and pain develop.

Forefoot Surgery Resulting in Imbalance

The function of the human forefoot is primarily twofold, transmission of the body weight to the ground and propelling the body forward in locomotion. This action is facilitated by the grasping mechanism of the toes,[7] which in so doing minimizes the individual trauma sustained by each metatarsal segment (metatarsal and its associated phalanges) otherwise plantar keratoses develop under the involved metatarsal heads from overloading, and excessive contracture of the phalanges are associated with dorsal helomata. It is essential therefore that the reciprocal toe-grasping and metatarsal-splaying be in balance, otherwise disability and pain will develop. As the distinguished anatomist, F. W. Jones has written, "the key—to remember is that the digital flexors and extensors act synchronously and not alternatively, and that in doing this they act from their insertions in the toes and not from their origins in the leg."[8]

Simultaneously as the muscles and ligaments of the toes balance those of the metatarsals, in a longitudinal direction, there is also a horizontal or lateral function in which the body weight and counter shock from the ground is received at the fifth metatarsal segment and transferred to the first for final propulsion in walking, etc. The key structure in this function is the integrity of an intact Transversus pedis muscle which joins the fifth metatarsal to the first and thereby inhibits splaying of the metatarsals.[9]

Case 5—Surgery on the Fifth Metatarsal Segment

This surgery is usually performed for relief of a chronically painful heloma on the dorsum of the fifth toe together with a recurring keratosis under the head of the fifth metatarsal. Theoretically this operation seems to offer an ideal solution to this problem. It is only when the heloma recurs on the fourth toe and the keratosis persists under the fifth metatarsal head, that it is realized that the basic function of the forefoot has been disturbed. I have seen patients who have also had their fourth toe amputated and others with even their third toe as well, in seeking relief from pain. Surgery, in this instance, did not relieve the problem. It merely worsened it. It is surprising how many of these cases respond to simple crest therapy. This treatment restores some of the lost reciprocal toe-grasping versus metatarsal-splaying action and is sufficient to provide comfort and even disappearance in many cases of the dorsal heloma.

Case 6—Surgery on the First Metatarsal Segment

In contradistinction to surgery on the fifth segment, where amputation of one portion or the other appears to be prerequisite to functional imbalance, mere osteotomy is sufficient to produce the same disability in the first. The reason or cause, I believe, for this disability is due to incision and disruption of the attachment of the Transversus pedis muscle. Time will tell whether the "sling procedure" devised by Joplin[10] (in which he transplants an extensor tendon connecting the fifth metatarsal to the first), will serve as a secondary Transversus pedis muscle. The most perplexing aspect to this problem is the surprising number of patients seen who have undergone two or more operations. It is my opinion that, with rare exception, if the first operation has proven a failure, we should strongly urge these patients to avoid further surgery. The imbalance which results usually thrusts undue weight, for body propulsion purposes, onto the head of the second which can be readily eased by fitting the patient with an accommodative appliance for the second and mild dispersive padding for the remainder of the forefoot region. This seems to be quite successful except where more than one

Fig. 2

Fig. 3

operation has been performed. In the latter instance, I have found that because of adhesions and surgical resection of the first metatarsal head, it is no longer capable of bearing weight. This then poses us with a very painful foot that is definitely disabled. Sometimes a rubber-butter mould to simply cushion the forefoot and minimize all medial weightbearing offers a degree of functional restoration and relief of pain. Figure 2 illustrates a good example of the head of the first metatarsal practically resected as a result of three separate operations to correct a severe hallux valgus.

Case No. 7

In some instances there is insufficient removal of bone, with the result seen in Fig. 3. Fortunately this patient had an obvious midtarsal fault which, when combined with a Morton's extension appliance, immediately provided the patient with dramatic relief from pain.

Case No. 8

Occasionally a patient will report, as in this case, following surgery for apparently a severe hallux valgus with contracture of the second toe as well, both conditions operated upon at one time. While this type of surgery was commonly seen, it is not too commonly seen today. I have yet to see a successful result of this surgical technique. Not only is the medial side of the forefoot thrown into imbalance, but as a consequence additional stress is placed on the central metatarsals, in particular the fourth metatarsal head. This patient was made comfortable by being fitted with an accommodative inlay for the fourth metatarsal head bilaterally.

Case 9—Surgery on the Central Metatarsal Segments

Figure 4 illustrates an unusual case of amputation of the entire second metatarsal segment, following complications of a hallux valgus.[11] This patient has undergone a total of six separate operations on her forefoot. The lady suffers constant pain due to functional impairment, as a result of bony ankylosis of the first segment, innumerable adhesions and digital contractures;

Fig. 4

Fig. 5

throughout the remainder of the metatarsophalangeal joints there is marked limitation of motion with subsequent reduction of the plantar fat pad. Even an accommodative appliance with extensive soft padding fails to relieve the pain to any great extent. Her only relief seems to be provided by periodic reduction of the plantar lesions followed by gentle massage.

Case No. 10

Figure 5 illustrates the classic amputation of the third metatarsal segment with osteotomy of phalanges of the second and fourth toes due to shrapnel wounds. As a result of some excellent surgery, this patient ex-

Fig. 6

periences a minimum of disability, and his only discomfort is due to a slight tyloma under the second and fourth metatarsal heads. Simple reduction of the tyloma suffices. Note the hallux valgus present together with contracture of the fifth phalanx; yet neither of these segments present any pain or functional disability.

Case No. 11

Figure 6 is of a case of amputation of the second metatarsal segment following radiation ulceration (for a plantar wart). The other foot was amputated above the ankle for gangrene following radiation for the same type of lesion. This patient still suffered from two draining sinuses; one in her heel and one over the site of the removed second metatarsal head. A rubber-butter mould with accommodations for the sinuses gave this patient her first relief from pain in 27 years.

Case No. 12

This case is a combination of surgery on the central phalanges combined with resection of the fifth metatarsal head. This represents the end result of a series of four separate operations on this patient's feet. I have seen a number of similar such cases. They all report in with chronic pain, extreme disability and literally beg for anything that will offer some kind of relief. The major problem is that resection of the fifth metatarsal head has unbalanced the lateral stability of the forefoot. Thus, compounded with the adhesions from the lesser toe surgery permits only to achieve a moderate degree of comfort with a well-padded metatarsal brace.

Summary

A selection of 12 cases has been presented, illustrating what the author believes contributes to functional disability following surgery on the various parts of the human foot. Some reasons why disability develops has been offered, together with the treatment employed to restore some degree of functional balance and use. The foot has been divided into three major parts, viz., rearfoot, midtarsal and forefoot for discussion purposes. By studying these failures, podiatrists may be in a better position to help these patients obtain some degree of relief from postoperative pain and disability.

Conclusions

1. Amputation at or below the ankle joint with some residual motion in the ankle joint is best treated with a moccasin prosthetic, rather than an amputation boot.
2. Midtarsal surgery should be followed by an appliance to restore some function to these inclined planes of bony wedges to serve as a foot shock absorber and reducer.
3. Amputation or resection of either the head phalanges of the fifth metatarsal segment leads to extreme disability and pain due to disruption in the anchorage of the Transversus pedis muscle. Crest-therapy will restore some of the lost reciprocal toe-grasping vs. metatarsal-splaying action of this part of the foot.
4. Osteotomy of the first or central metatarsals and their associated phalanges should be fitted with an accommodative appliance. It is suggested that postoperative disability develops with pain as a result of incision of the Transversus pedis muscle thereby permitting maximum splaying of

the metatarsals with medial and central overloading of these segments

240 Tegler Bldg.

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A New Instrument for Digital Surgery

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The various technics for surgical management of hammer toe include capsulotomy, tenotomy, wiring of phalanges, excision of portions of phalanges and metatarsals, and remodeling of the interphalangeal articulation.

Shands[1] says, "The object of all operative treatment is to improve function. Operation should never be performed at the risk of decreasing function, lessening needed stability, or leading to pain. Lesions of the bones and joints and allied structures often require a longer time for healing than do those of other tissues of the body."

A technic which meets these criteria, suggested by Hauser[2], and described by Mowbray[3] and DuVries[4], involves resection of of the head of the proximal phalanx through a dorsal incision. This approach usually requires incision of the extensor tendon in order to obtain an adequate field for capsulotomy and/or bone resection.

An instrument has been devised which will simultaneously retract the extensor tendon and dorsal soft tissue and elevate the head of the bone and the joint involved. This considerably reduces the size of the surgical field and the surgical trauma involved in an area comparatively poor in blood supply and drainage.

The working end of the instrument, .032 thick and 3/16 wide, is shaped in the form of a double curve as the letter "S". The top

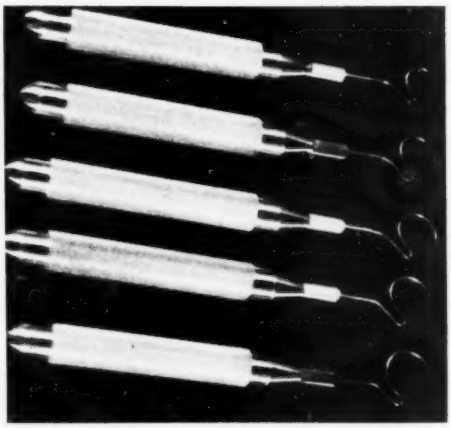

Fig. 1—5 sizes of the instrument

curve is markedly flattened, being just deep enough to contain tendon and dorsal tissues. The lower curve has been designed in varying sizes, to accommodate to varying sizes of bone. Five basic sizes have been developed with openings of .338, .405, .475, .545, and .615 ins. (Fig. 1). The instrument is made of stainless steel.

The instrument is held with the larger opening upward (Fig. 2) and introduced through a dorsolateral incision under the extensor tendons and over the shaft of the bone at the junction of the distal and middle thirds of the proximal phalanx in a hammer toe operation. The instrument is then rotated against the bone so that it encloses only the bone while retracting the

Fig. 2—Instrument in position for insertion into incision, after which it will be rotated.

dorsal tendon and other tissues. The instrument is then moved distally to expose the joint capsule and retract the dorsal aponeurosis as much as possible. It is now possible to incise the joint capsule and expose the head of the phalanx. The head of the bone may then be excised or reshaped as desired.

The use of this instrument in indicated procedures produces less trauma, less displacement of tissue, and facilitates accessibility to deeper structures. This results in less postoperative pain, shortens healing time, and reduction of postoperative edema.

The instrument can be used in procedures other than for hammer toes and can be modified for additional uses. In private communications Cape (Royal Oak, Michigan) has suggested its use in arthroplasty of a metatarsal head; Walkes (New York, N. Y.) has suggested a hooklike modification of the edge of the instrument to facilitate introduction of a Gigli saw.

950 Hempstead Turnpike

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Clinically Speaking

A place for the more informal presentation of reminders, suggestions, notes, observations and technics of value in office practice. Your contributions of short manuscripts or illustrative case histories will determine this section's usefulness.

Accessory Calcaneus —A Case Report

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Accessory bones occur in the feet with considerable regularity and anomalies of this type are frequently reported. Shands[1] in roentgenographic studies of 850 children found that 7 percent had accessory bones of the feet exclusive of those found in the metatarsophalangeal area. In another study of 214 children past the age of 8 years 26 percent showed accessory bones. Although the literature is abundant with reports, cases, and studies on the subject of accessory foot bones, one finds little mention of the accessory calcaneus. Indeed, we were successful in locating only four such references.

Milliken[2] reported a case of accessory calcaneus in 1935. The patient was a 61-year-old farmer who complained of pain and distress in the heel. Pain had developed spontaneously as though a nail were coming through the shoe. Milliken found a mass on the plantar of the left heel that was visible and palpable, movable and tender on pressure. He excised this bone and found no articulation with the calcaneus; it measured 0.9 cm. in its greatest dimension. Patient recovery was uneventful. Milliken, concerned whether this was a true accessory bone, and not the result of an ossifying inflammatory process, concluded that it was a true accessory bone. He next considered why this bone had given no trouble till age 61, and further concluded that in youth the capacity of the body to adapt is greater, and that some

slight trauma probably triggered the symptoms.

Shands, in his study of 850 children, reports one case of accessory calcaneus in a boy 15 years of age. He excised this bone because it was the source of discomfort. The boy's heel became painless following its removal. After gross and microscopic study, Shands was uncertain as to whether it was a separate bone or a small fracture fragment.

Krida[3] describes a case report of secondary os calcis; he excised the bone due to painful symptoms. Krida described the bone as being less than ½ inch in its greatest dimension and as articulating with the head of the talus and cuboid.

Dwight[4] and others have described a bone located at the anterior aspect of the calcaneus as being a nonarticular, rough, ill-defined projection into the space between the navicular cuboid, and head of the talus. Pfitzner[5], acocrding to Krida, describes a similar bone as being found in 2 percent of 840 feet dissected. Another variation has been noted as being located in front of the sustentaculum tali.

We have searched the literature as far back as 50 years and the foregoing resume is all that we could find. Some reports leave a doubt as to whether or not these were true accessory bones. The case of Milliken is interesting, there is no doubt that the bone he describes is an accessory calcaneus, and it will be noted that the details of his case are homologous to those of the following presentation.

On January 5, 1960, a female, age 70, was referred to us by her physician with a complaint of painful right heel of about 2 years' duration. The pain occurred only on weightbearing and required the use of a piece of sponge rubber to be inserted in the heel of the shoe. The patient could recall no trauma and was unaware of any problem with the heel until 2 years previous, at which time the discomfort first became apparent. She related, "I was returning from the beach, walking in my bare feet, when suddenly it felt as if there was a stone in my heel, and it has hurt ever since that time."

Fig. 1. Accessory calcaneus. Note protrusion on plantar surface of right heel.

Examination of the area revealed a nodular mass in the central plantar aspect of the right heel, about the size of a half dollar in circumference and projecting plantarly enough so that when she stood on it one had the impression of a "built-in" high heel (Fig. 1 right). This mass was movable, both in the anteroposterior and the medial to lateral directions, and was painful on direct pressure. The left heel appeared normal by comparison (Fig. 1 left).

Fig. 2. Radiograph of accessory calcaneus.

Roentgenographic examination (Fig. 2) disclosed a supernumerary bone, cube-shaped, but having a similar configuration to the true calcaneus, and being situated directly below it.

It seems inconceivable that this bone could be newly formed. And almost less likely that she could have lived with it for 60 years and not have been aware of the difference in her two feet. This bone was so large, that, in truth, it did act like a

Fig. 3. Four-week postoperative appearance.

"built-in" high heel, giving the patient a pelvic tilt on the right side. After considerable interrogation the patient finally admitted that she always required alteration of her dress lengths due to one side of the hem being higher. This remained the only clue, insofar as history of the complaint is concerned, that substantiated the long existence of the bone.

Following further investigation into the role this accessory calcaneus played in the function of the foot we concluded that: there were no attachments to the plantar fascia or the tendo achilles, and that there was no appreciable shortening of the tendo achilles as might be presumed.

Inasmuch as her general health (as reported by the referring physician) provided no determent, we elected to excise the bone.

The patient was admitted to the hospital and the surgery performed under ankle block anesthesia, and through an incision on the lateral aspect of the heel this bone was extirpated. There were no tendenous or ligamentous attachments except for a capsule-like tissue connecting it to the calcaneus. However, there was no joint cavity. The bone measured 3.2 by 4. cm. Following closure the foot assumed a more normal shape indicating a good functional prognosis.

The postoperative recovery was uneventful. Weightbearing was proscribed for 4 weeks. The patient was then allowed to stand on the right foot and did so with no difficulty (Fig. 3). A quarter-inch felt raise was inserted in the heel of the right shoe but was not needed and was removed a few weeks later. At the 6-week postoperative visit the patient was observed to walk normally being totally asymptomatic and this again noted at the 6-months visit.

Summary

Accessory calcaneus is indeed rare. A unique case of this entity is reported. An accessory calcaneus may vary in size from that of a small ossicle to one as large as the cuboid bone. It appears that this accessory may be present for many years without manifestations and that there is no direct relationship between the size of the bone and the fact that it may or may not be symptomatic.

614 Newark Avenue

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Foot and Ankle Pain In a Carcinomatous Patient A Case Report

Mark L. Fine, D.S.C.
Rosemead, Calif.

A WHITE female age 58, presented herself with the following complaint: a stabbing pain in both feet and ankles. She was unable to walk or sleep from this pain. She gave a history of a malignant tumor of the lower intestine, upon which a cholostomy had been performed. She reported also, a recent kidney infection. Previous treatment consisted of wrapping with elastic bandage.

Both extremities, from the knee to the dorsum of the foot, showed marked pitting edema. Spider web varicosities were numerous on both limbs. The skin was cold and there was a yellowish cast to it. Uremic plaques were present. X-ray examination

showed no pathological bone, however, orthopedic defects were present. The achilles triangle was obliterated due to the edema. The oscillimeter showed little or no recordable peripheral blood flow. The dorsalis pedis, and posterior tibialis pulses were not palpable. There were no areas tender to palpation.

The patient's physician was consulted, and we were informed that she was suffering from advanced carcinoma of the lower intestine. He suggested that we try and make the patient as comfortable as possible.

The skin was prepared with tincture of benzoin, and a flexible casting was applied to the foot and ankle in a figure of eight fashion, and carried up to the knee. This was done bilaterally.

The patient reported the following day by telephone that she had slept well that night. Three days later she reported to the office, with no complaints of pain. She was able to ambulate relatively free from pain.

The carcinoma had advanced to the kidney causing the edema and extra strain on the foot. By palliative care we were able to relieve some of the strain factors, and the pain.

4023 No. Rosemead Blvd.

Squamous Cell Carcinoma —A Case Report

Leonard A. Zingler, D.S.C.
Hackensack, N. J.

A WOMAN, age 55, white, came to the office complaining of pain between her third and fourth toes of the right foot. Upon examination a lesion was present which appeared to be an ulcerated soft corn, about ¼ inches in diameter. Upon questioning her, I was informed that she had previously been to her physician who told her that it would go away on its own. She also told me that she recently had some surgery done.

The lesion was treated with silver nitrate, 25 percent and the patient was instructed to return in 1 week. In the meantime, I spoke to her physician and was informed by him that the patient had undergone surgery for removal of inguinal lymph nodes because of malignancy. When the patient returned the following week, the eschar caused by the silver nitrate was removed and now the lesion took on the appearance of a verruca, so a salicylic acid ointment was applied in an aperture pad.

The patient returned in 4 days with the same pain present. After removing the sloughing tissue, I again applied silver nitrate, 25 percent. A urinalysis was negative and X-rays showed no bone involvement. Wet dressings of Domeboro®[1] solution were prescribed for 1 week. This time when the patient returned, the lesion seemed cleared up. The patient was discharged for three weeks.

Upon returning to the office, examination showed the growth had reoccurred with the original pain present. Decision was made to excise the entire mass, and the specimen was sent to a laboratory for study. The report was, "Well differentiated squamous cell carcinoma of the skin." The site of the lesion healed completely in 2 weeks without any symptoms.

This case illustrates that innocent-looking lesions can be deceiving and the importance of laboratory examination.

10 Banta Place

[1] Dome Chemicals, Inc.

Plexiform Neuroma of the Great Toe— A Case Report

Jerome Shapiro, Pod.D.
Washington, D. C.

Miss A.P., a 49-year-old unmarried white female, presented herself at our office with the complaint of a painful callus at the plantar aspect of the interphalangeal joint of the great toe, right foot. She stated that she had been bothered by this lesion for the past 7 years and had received monthly treatment which consisted of palliative reduction of the callus and paddings. About 3 years ago, she stated, a wart was burned out from this area. In spite of this long history of treatment she noted no improvement and there has developed during the

past 6 months a lancinating type of pain in the area which would even occur in bed at night.

Examination revealed a plantar callus overlying the plantar aspect of the interphalangeal joint of the great toe of the right foot. When the callus was reduced a definite firm, freely movable, palpable mass was felt which, to my own clinical judgment, was consistent with that of an adventitious bursa.

Following the usual blood and urine examinations and X-ray studies which proved negative for any bony pathology, the following procedure was performed: Under a local anesthetic and the application of a rubber band tourniquet, two semi-elliptical incisions were made 2 cms. in length each and the enclosed skin wedge was removed. The incision was deepened to expose a fairly solid, whitish, encapsulated, egg-shaped mass approximately 2 cms. in length in its widest dimension. The mass was bluntly dissected out and closure was made with 000 dermal silk. The patient healed uneventfully with no recurrence of symptoms.

Report of examination of tissue revealed the following: Sections of tissue from the right foot revealed it to be covered by a hyperkeratotic, orderly, stratified squamous epithelium. In the underlying dermis and subcutaneous zone there were increasing numbers of nerves, many of which formed an interlacing pattern. This type of lesion is consistent with a proliferation of nerve tissue, with the formation of neuroma. No malignant manifestations were noted.

5429 Connecticut Ave.

"Research seeks not to prove something but simply to gain accurate information and understanding. To maintain its integrity it must be free of any effort to prove something its sponsors wish to believe or wish others to believe."

Charles E. Scripps
The Scripps-Howard Newspapers

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A. RUBIN, D.S.C., Editor

Communications regarding manuscripts, news items, and editorial matters should be addressed to the Editor, those regarding advertising to the National Advertising Representative.

President's Page

At my request, President Elect Shor has provided the "message" this month.

Marvin D. Marr, D.S.C.

Progress . . . Advance to an objective; gradual betterment.

Recently the Medical Liaison Committee prepared a "Special Report" designed to establish the basis upon which firm hospital privileges may be obtained for Podiatrists-Chiropodists. The members of the Committee must be commended for their realistic and objective approach in preparing this report. As a result of much study and deliberation they developed a set of policies based upon serving the best interests of the public in cooperation with the other members of the healing professions. In formulating the rules by which our profession must regulate itself in order to obtain hospital privileges in cooperation with medical doctors, two primary areas of disagreement became evident: 1) the extent to which podiatry services in hospitals are related to or synonymous with foot surgery privileges and, 2) the extent to which the overall responsibility for the patient's medical care should properly be entrusted exclusively to the podiatrist where surgery is to be performed under a general anesthesia.

The first area of disagreement may be overcome by our members making a concerted effort to acquaint the medical profession with the broad scope of services which the podiatrist can perform in the overall interest of the hospital patient—a scope in which surgery occupies only a very limited role. The second

area poses a direct challenge to our own profession. We must recognize the necessity for placing the welfare of the patient above both our own pride and our own economic self-interest if need be.

For a moment let us look at the other side of the ledger. In many hospitals throughout the country, the general practitioner, too, has encountered severe restrictions with regard to hospital surgical privileges. Typical complaints from members in the "American Academy of General Practice" are as follows: From Louisiana, "All men who are not doing general surgery at the present time must have two years' approved surgical residency to do major procedures." From Wisconsin, "Withdrawal of surgical privileges because individual is not board certified, or a member of the ACS. Hospital policy not to permit G.P.'s to assist with the surgery of their referred patients." And there are many others.

Your Medical Liaison Committee is aware that medicine comes in for direct criticism by its members regarding hospital privileges. These medical members who are not themselves allowed the use of hospital facilities become our greatest critics. This becomes an added problem for podiatry which is not of our doing.

"Good surgery cannot be measured by the number of operations performed or assisted." "Merit alone is the only criteria for judging surgical abilities." And this is exactly the point. In order that the surgical abilities of podiatrists may be judged, we must gain admittance to hospital staffs so that the staff may be exposed to the podiatrist's ability. We can only do so if we exercise mature judgment and self-restraint. Your committee never doubted the ability of podiatrists to perform surgery. Before any further discussions could continue with the various organized medical groups, a statement of our position evidencing this maturity was necessary. It must be further understood that your officers and Board of Trustees reflect the collective conscience of the A.P.A. Before accepting the philosophy personified in the Medical Liaison Committee Report, every word and statement of position was weighed with that responsibility in mind. These, then, were the considerations weighed and evaluated by the Committee in setting forth its answer to the troublesome question as to who will accept the overall responsibility for the patient's medical care in the event of an emergency.

In our reasonable desire to gain acceptance as a member of the health team, let us avoid any temptation to insist upon extremes. "What patience was here that toiled in countless milleniums to carve a single crevassed face . . . can be spoiled, all, by one word in one second."

ROBERT SHOR, D.S.C.

Foot Health Week

All members are reminded that Foot Health Week is May 14-20, inclusive. Every state office has been provided information and materials for programs within the state. If you have not already been contacted by your state officers or committees, why not offer your services?

Podiatry-Chiropody Abstracts

Jerome Shapiro, Pod.D.
5429 Connecticut Ave., N.W.
Washington, D. C.

Editors of Local, State and Regional Publications are requested to provide copies to Dr. Shapiro who is editing this section of the Journal.

Local Anesthesia

A. J. Mazzaglia, D.S.C., New England Journal of Podiatry, Mar. 1959.

The author has attempted a general discussion on the use of local anesthetics. He stresses the importance of a thorough knowledge of the anatomy of the area involved to prevent nerve damage and vessel penetration. Different methods of inducing local anesthesia are discussed. In his discussion on preoperative sedation he stresses the importance of taking the patient's blood pressure, respiration and pulse rate prior to administration of the anesthetic, so that they can be restored should the need arise. He mentions the pros and cons of incorporating hyaluronidase and vasoconstrictor agents with the local anesthetic. Some interesting points made in relation to testing for drug sensitivity and treatment of sensitivity reactions to the drugs. The article is concluded with a general discussion on aseptic surgical techniques and methods of maintaining hemostasis. This is a well written article and should be read by all those who use local anesthetics in their practice.

Rationale of Zondex Vapor Therapy In the Treatment of Onychomycosis

Harry W. Weinerman, Pod.D., The British Chiropody Journal, Vol. 25, No. 4, April 1960.

One of the difficulties in the treatment of onychomycosis is the inability of the fungicidal agents to penetrate the nail structure even after most of the nail has been burred. This is further complicated by the fact that the fungus organisms transform themselves into spores which render them impervious to standard fungicidal agents. With this thought in mind a search was made for a fungicidal agent with a deep penetrating power. The vapors of Zondex®[1] are known to penetrate leather and therefore it was felt that this high power of penetration might also affect nail tissue. A special cabinet was designed which could house the foot under treatment. The foot is exposed to the vapors for 10 minutes every 3 days. This treatment was continued until there was some evidence of improvement. Instead of the cabinet, polyethylene bags may be used. Although the results are inconclusive, they do suggest some beneficial results. Of course the patient is advised to continue the fumigation of the footgear to prevent reinfection.

®[1] Gross Padow Corp.

Chymotrypsin®[1]: A New Drug For Use in Podiatry

Richard D. Lucas, D.S.C., Current Podiatry, Vol. 9, No. 3, March 1960.

Herein are reported fourteen case studies utilizing Chymotrypsin. Two forms were used: an aqueous injectable and a topical. The case involved the following clinical entities: exfoliative dermatitis, contusions, ulceration, postoperative necrosis following nail surgery, heloma neurofibrosum, infected plantar ulcer, epidermophytosis and traumatic laceration. Along with the enzyme therapy standard therapeutic regimens were employed, viz., wet dressings, antibiotics, ultraviolet ray. The author feels that Chymotrypsin is an excellent addition to the armamentarium of the podiatrist.

®[1] Columbus Pharmacal

Amputation of All Toes—A Review Of Forty-seven Amputations.

Michael Flint and Rodney Sweetnam, The Chiropodist, Vol. 15, No. 10, Oct. 1960.

Fixed clawing of the toes with dorsal dislocation of the metatarsal phalangeal joints is often seen in patients with advanced rheumatoid arthritis, pes cavus and severe hallux valgus. The toe deformities at times produce marked restriction of activity and a great deal of pain. Some patients can be made comfortable by regular chiropody and special shoes. In moderate fixed deformities of the toes, arthrodeses of the interphalangeal joints are helpful but in the severe clawing with associated metatarsophalangeal dislocations, these minor procedures are ineffective. Excision of all the metatarsal heads have been performed as well as removal of the bases of the proximal phalanges, reshaping of the met heads and excision of intractable calluses. It is the belief of many surgeons, including the authors, that preserving stiff deformed functionless toes is of no value and therefore they have reported the following results using a method of amputation of all the toes for fixed toe deformities in rheumatoid arthritis, hallux valgus and pes cavus.

The results of 47 amputations in 28 patients are analyzed and 93% were found to be satisfied with the operation. The amputation of the deformed toes removed both the cause of local pain and disability and also the downward thrust on the metatarsal heads which aggravated the metatarsalgia. The technique had no adverse effect on gait or stability. The technique of the operation is described as well as postoperative management. The importance of retaining full length shoes fitted metatarsal insoles and toe blocks to preserve a good gait and balance is emphasized.

Foot Strain in the Middle-Aged

Franklin Charlesworth, F.Ch.S., The British Chiropody Journal, Vol. 25, No. 5, May 1960.

Foot strain is defined as a condition in which excessive stress results in functional defects causing pain. This can happen one of two ways. Following a long illness where one has been off weight bearing for some time and then assumes ambulation, the normal stress of minimal walking may be too much for the foot structures, namely the muscles and ligaments. The muscle is inadequate and therefore cannot sustain the proper bony alignment. This puts an increased load on the ligaments and produces strain which in turn causes pain. Here abnormal structures submitted to normal stress have produced strain. We may also encounter foot strain when normal structures are submitted to stresses beyond normal as is the case in perhaps a traffic policeman or one who is forced to carry heavy loads. This may also occur when one undertakes increased sports such as 18 holes of golf. Another cause may be sudden weight gain. During this process, the overtiring of the muscles decreases their tonus putting more burden on the ligaments which in turn become stretched causing the osseous structure to sag and pain to occur. Varicosities may also start the process off by causing muscle fatigue and decrease of muscle tonus.

In his brief discussion on treatment, Dr. Charlesworth discusses the use of elastic hose, rest, Buergers exercise, the use of insoles with a lateral heel flange and a cupped heel seat, and shoes properly fitted with a medial heel wedge and a lateral sole wedge.

Even in a single leaf of a tree, or a tender blade of grass, the awe-inspiring Deity manifests itself.

—from the Japanese

The Merck Index of Drugs and Chemicals, Seventh Edition

Paul G. Stecher, Editor, published at cost as a professional service, $12.00, printed in clear type on English finish paper, size 7⅛" x 9⅞", bound in dark blue Sturdite cover resistant to water, acid and mildew, and stamped in gold. Completely new Index contains about 1,600 pages of text covering nearly 10,000 descriptions of individual substances, more than 3,300 structural formulas, and about 30,000 names of chemicals and drugs alphabetically arranged and cross-indexed, Merck and Company, Inc., Rahway, N. J., 1960.

The previous edition of the Merck Index was published in 1952 and 100,000 copies were purchased before the supply was exhausted during 1958. The new edition includes extensive scientific advances during the past eight years. An outstanding feature of this new book is a separate and greatly expanded cross-index section of more than 30,000 names. This enables the user to locate a particular chemical description by page number regardless of whether he knows only the generic name, brand name or systematic chemical name of or for a substance.

A special section lists more than 400 organic "Name" reactions with original and review references, together with a description and structural representation of each reaction. There is an up-to-date periodic table arranged in accordance with the latest concepts of nuclear science, a table of international atomic weights and close to 300 pages of appendices on such subjects as chromatographic adsorbents, calories in foods, Russian alphabet, biological units, coal-tar colors, thermo-metric equivalents, antifreeze mixtures, saturated solutions, radioactive isotopes, percentage solution tables for apothecaries, isotonic solutions and atomic weights and their multiples and logs.

Each main entry indicates the preferred chemical name or other chemical names, common or popular names, generic and trade names. Trademark listing is as complete as can be and thoroughly cross-indexed.

Properties and sources of substances, preceded by methods of preparation, with references, are given, followed by indication of uses, whether medical, industrial or veterinary. Hazards, toxicities and other safety factors are mentioned. Indication is given of commercial availability and grades such as U.S.P., N.F., and reagent. Empirical formulas, molecular weights and percentage composition are given for all chemicals having a definite structure.

The purpose of Merck's Index is to provide for all who have to do with medicinal and chemical matters, one handy volume as a ready means of quickly and reliably answering questions of fact that may arise in any direction in the midst of their work.

Instead of having to consult several materia medica manuals, chemical dictionaries, dispensatories or other works of different scopes, the reader will find here all those various directions of research in one alphabetic, concise and lucid series of descriptive paragraphs, under the heads of the several substances concerned.

Editorial preparation of this excellent publication was carried out by the Technical Information Department of Merck's Research and Development Division under the editorship of Paul G. Stecher, who also headed the Sixth Edition editorial staff. In addition to members of Merck's scientific staff, many outside consultants collaborated in the compilation and checking of material.

This is a most unusual reference book and the writer highly recommends it as a most informative and educational volume for your office.

Harry L. Hoffman, D.S.C., Ph.G.

Diseases of the Nails

V. Pardo-Castello, M.D., Assistant Professor of Dermatology and Syphilology, University of Havana Medical School and Osvaldo A. Pardo, M.D., Instructor in Dermatology, University of Havana Medical School, Third Edition, $8.50, 113 photographs, Index and 461 choice references. Published by Charles C. Thomas, 301-327 East Lawrence Ave., Springfield, Ill., U.S.A., July 1960.

The authors' special interest in this field has resulted in a clinical guide which contains practical information not to be found elsewhere except in scattered form, if at all. The text contains the newest additions in medical literature as well as the authors' own recent observations and experiences. Not only are the latest concepts and methods set forth, but in addition the authors included the list of 61 occupations in which nail affections are common, together with their symptoms and causes.

The authors' comments on the use of Griseofulvin are stimulating and thought provoking. They remind the reader that Griseofulvin is well tolerated, except in rare cases, that it is important to remember that Griseofulvin used locally in creams, ointments, solutions, suspensions or in powder form, is not effective; and that its fungistatic action is due to its chemical combination with keratin and therefore its use as a local preparation is not recommended.

Every chapter requiring revision has been brought up to date. There are many outstanding features in this book, such as chapters on Anatomy and Histology of the Nails, Pathology of the Nails, Affections Peculiar to the Nails, Onychodystrophies, Ungual Manifestations of Dermatoses and of Systemic Diseases, Congenital Affections of the Nails, The Roentgen Ray Treatment of Diseases of the Nails, Occupational Affections of the Nails and Ungual Symptoms Due to Drugs and Poisons.

This reviewer was impressed, as others have been before me, with the meticulous care and choice of words and authors' use in referring to the various diseases and descriptions of the nails. The excellence of the material found in this book is unsurpassed. Every podiatrist who deals with diseases of the nails will find this new third edition a combination of good common sense and keen insight into the nail problems. Throughout, the special approach required for optimal end results is set forth with a simplicity and soundness that aptly reflects the authors' many years of clinical practice and investigation. With the integration of the anatomic and pathologic specimens, it forms a solid basis for accurate clinical diagnosis.

The illustrations are numerous, clear and instructive. This book is of practical value to all practitioners because it is written in an easy and enjoyable style and because it represents an enormous amount of work by the authors. The additions and revisions make this book the indispensable reference tool it is. The authors and the publishers are to be congratulated on their accomplishments in the printing of this new third edition.

Jack Ranzer, Pod.D.

It would seem as if the rulers of our time sought only to use men to make things great: I wish they would try a little more to make great men: that they set less value on the work and more value on the workman.

—de Tocqueville
1804-1859

Pharmaceutical Preparations for the Profession

Harry L. Hoffman, Ph.G., D.S.C.
Chairman, Council on Podiatry Therapeutics and Pharmacy

A column devoted to preparations, new and old, with emphasis on their value and uses in everyday chiropody practice. This is a regular monthly column prepared from information furnished by the pharmaceutical house. We invite questions, which we shall endeavor to answer, or obtain the answer.

Temaril Tablets, Spansules and Syrup

Generic Name: Trimeprazine.

Description: A new oral medication for the relief of itching regardless of cause.

Composition: Each tablet and each 5 cc. teaspoonful of syrup contains 2.5 mg. of trimeprazine, S.K.F., as the tartrate. Each Spansule (capsule) contains 5 mg. of "Temaril," brand of trimeprazine, a phenothiazine derivative with antipruritic activity.

Advantages: In extensive clinical tests, "Temaril" has been found effective in the relief of more than 70% of all cases of moderate and severe itching, regardless of cause. It often relieves itching which does not respond to any other therapy. Side effects, when they occur at all, are generally brief and of short duration.

Uses: Pruritus regardless of etiology. Its usefulness has been demonstrated in pruritus of widely varied origins, both dermatologic and non-dermatologic.

Administration and Dosage: Dosage should be adjusted according to severity of the symptoms and the response of the patient. The majority of patients will obtain optimal results when "Temaril" is used for both daytime and nighttime therapy. Usual dosage for adults is 5 mg. at bedtime and 2.5 mg. at breakfast and lunch (or at lunch and supper if the nighttime dose carries the patient through the following morning). If itching is primarily a nighttime problem, doses of 5 to 10 mg. at bedtime may be effective without supplementary daytime doses.

Temaril Spansule (capsule) in bottles of 30. This is a new form in a long acting capsule. When continuous action is desired, a single mg. capsule every 12 hours. If itching is primarily a nighttime problem, 1 or 2 capsules at night may be effective without a supplementary daytime dose. In some resistant cases, patients may require as much as 30 mg. in 24 hours for relief.

In children from 6 to 12 years, the recommended dosage is 1 capsule daily. In severe cases, recommended dosage is 1 capsule every 12 hours. Daily dosage should not exceed 10 mg., however.

Caution: Since this drug is a phenothiazine derivative, it should be administered discriminately, and its use should be attended by careful and regular observation. Mild and temporary drowsiness is the most frequently encountered side effect, but tolerance to this effect usually develops after a few days of medication. Patients should be observed regularly and watched for possible occurrence of agranulocytosis or other serious side effects seen infrequently with some phenothiazine derivatives. Because virtually all reported cases of agranulocytosis associated with the administration of phenothiazine derivatives have occurred between 4th and 10th weeks of treatment, patients on prolonged therapy should be observed with particular care during that time.

Supply: Available in tablets in bottles of 50 and 500. Spansules in bottles of 30. Syrup in 4 oz. bottles. By Smith, Kline and French Laboratories, Philadelphia 1, Pa.

Typical Prescription

Rx Tabs Temaril 2.5 mg.
Disp. # XXX.
Sig: 2 tabs. at bedtime and 1 at lunchtime

Prescriptions for children:

Baby (ages 0-2)

Rx Temaril Syrup 120 cc.

Sig. ½ tsp. at bedtime. If indicated ½ tsp. at 1 or 2 meals.

Note: Total daily dosage should not exceed 5 mg. (2 tsps.).

Typical Prescription

Rx Spansules Temaril 5 mg.
Disp. # XXX.

Sig: One (1) at bedtime.

Children (ages 2-12)

Rx Temaril Syrup 120 cc.

Sig: 1 tsp. at bedtime, and if indicated a tsp. at 1 or 2 meals daily.

Note: Total daily dosage not to exceed 10 mg. (4 tsps.)

Digests From The Literature

Anyone wishing to read the complete article, if not available in your local library, may borrow it through interlibrary loan. A microfilm may be borrowed from the National Medical Library, Washington 25, D. C., or a photo-duplication may be obtained from that library.

Dermatology

Oral Treatment of Dermatomycosis and Onychomycosis with Griseofulvin, Bodian, E. L. Internat. Rec. Med. 173: 85-87, 1960.

Forty-five patients with proved *Trichophyton* or *Microsporum* infections of the hair, nails, or skin, who had obtained only transient or symptomatic relief, if any, from various preparations, were given griseofulvin 250 mg. three or four times daily (except children who received a 250 mg. tablet daily). Treatment was continued until laboratory and clinical evidence of eradication of the fungus was complete. This required 1 to 6 weeks in cases of dermatomycosis, and up to 5 months in cases of onychomycosis. Relief from pruritus occurred in the first 2 to 4 days. In 1 week vesicles were drying and erythema and maceration had decreased. In 2 weeks the hyperkeratotic layer sloughed off.

Healthy nails in patients with onychomycosis were noted in the third to fourth week. Thick, dystrophic subungually hyperkeratotic nails became normal in 4 to 5 months. Side effects occurred in three patients; nausea in 2 patients, requiring discontinuance of the drug in one of them, while the drug was continued in lower dosage in the other without nausea following. Another patient had abdominal discomfort for the first few days.

Treatment of Dermatomycoses with Griseofulvin, Yontef, R. J. Med. Soc. New Jersey: 738-40, 1959.

Griseofulvin (Fulvicin®), a fermentation product of penicillin, was given orally 250 to 500 mgm. four times daily to 15 patients with proved superficial fungus infection. The highly resistant dermatomycosis had persisted in these patients for years unbenefited by various therapies. Four patients suffered transient side reactions. A boy developed painful erythematous papules on the scalp which responded to hot, wet dressings. A young woman developed a transient sweat-gland-retention syndrome during treatment, which disappeared without the dosage being lowered. A man developed persistent radiating pains in the chest. A woman had gastric distress and nausea which disappeared when treatment was discontinued, and recurred mildly when administration of the drug was resumed, with antiacids given concurrently.

Griseofulvin in oral doses of 1 to 2 gm. daily brings rapid relief of *Trichophyton* and *Microsporum* infections of the hair, skin and nails. The most amenable to therapy are *Microsporum* infections of the glabrous skin; intertriginous dermatomycoses are more resistant and tend to recur on re-exposure to infection. Prolonged therapy is required for onychomycosis. If the nails are affected, treatment should in-

clude local fungicidal measures and mechanical removal of debris. At least 8 weeks of treatment are required for significant improvement. All of the 15 patients were improved or cured. One patient with a dermatosis mimicking dermatophytosis, but which proved to be nonfungal in origin, did not respond to griseofulvin therapy.

®Schering

Griseofulvin Therapy of Superficial Cutaneous Mycoses, Everett, M.A., and Alston, H. D. J. Oklahoma M. A. 52: 793-95, 1959.

Griseofulvin was administered to 25 patients with proved chronic fungous infection of scalp and body—250 mg. daily to adults four times daily, to children (aged 4 to 9 years) three times daily, to smaller children twice daily. Single weekly doses ranged from 2 to 3 gm., according to body weight. Three treatment schedules were used: (1) daily administration for 14 to 60 days; (2) daily administration for 7 to 14 days followed by weekly administration; (3) weekly administration only. After lesions were clinically and microscopically cleared, medication was continued for 7 more days.

Patients who received daily treatment for 14 days or more were cured. Most of those receiving weekly therapy for 3 to 6 weeks following treatment daily for 14 days, and those receiving continuous therapy for 21 to 42 days were cured. Those receiving only weekly therapy, or continuous therapy for less than 10 days, did not respond. *Trichophyton tonsurans* infection cleared after 6 weeks of daily therapy. *Trichophyton schoenleini* infection cleared after 28 days of continuous therapy. *Trichophyton rubrum* without nail involvement failed to respond to weekly therapy but cleared after 14 days of continuous treatment followed by 4 weeks of weekly therapy, or after 28 to 42 days of continuous treatment. Patients with *T. rubrum* involvement of the nails need 4 to 8 months of treatment.

In 3 patients the drug had to be discontinued because of side effects; 2 had nausea, vomiting and headache; a third had fever and a maculopapular eruption. In general, results seemed to be more consistent following daily rather than intermittent therapy.

Diabetes

A Skin Test for Diabetic Screening. Physicians Bull. (Eli Lilly) 25: 34-35, March-April 1960.

A skin-surface glucose test was devised following the observation of some diabetic patients that when testing their urine the glucose-oxidase test paper (Tes-Tape) the part held between their fingers showed a positive reaction—usually when the urine contained sugar. Tests were made of 86 diabetic and 67 nondiabetic ambulatory patients, including urine, blood and skin tests. A strip of Tes-Tape moistened with water was held between thumb and forefinger of each hand. The test was called positive if the color changed. Occasionally only one hand showed a reaction—this was not explained.

Of the diabetic group 42 of the 86 had positive reactions in all three tests; in 19 patients with well controlled diabetes the three tests were all negative. In 15 patients with positive skin test, the urine test was negative, but 7 of these showed a positive blood test. These 15 patients would not have been discovered without the skin test. Of the remaining patients, 5 with hyperglycemia had negative skin and urine tests. Only 2 of the entire group had hyperglycemia and glycosuria and a negative skin test.

The skin test is a test of hyperglycemia, not diabetes alone, for 3 patients with transient hyperglycemia due to cerebrovascular accidents had all positive tests, skin, urine and blood. Of the 64 other nondiabetics (controls), 53 (82.8 per cent) had negative tests entirely. However, 11 nondiabetics had positive skin tests, but 7 of these patients proved to have abnormal glucose tolerance and impaired carbo-

hydrate metabolism; 2 others had borderline cases. These 9 patients would have been missed except for the skin tests.

The fact that skin sugar content reaches its maximum several hours later than blood sugar, may explain why skin and blood tests did not always coincide. Since the skin comprises 16 per cent of the body weight, this simple, convenient skin test may prove valuable as an adjunct to the present screening devices used for detection of diabetes mellitus.

Drugs

For Better Control in the Distribution of Drugs, Tice, L. F. (Editorial). Amer. J. Pharmacy 131: 366-68, 1959.

Too often the pharmacist is held responsible for improper distribution of prescription drugs, so that they get into laymen's hands in large amounts—especially central stimulants and hypnotics. Too much laxity is involved in distribution of drugs *before* they reach the practicing pharmacist. Law enforcement places great pressure on the pharmacist to prevent his becoming an illicit source, but exerts little effort at the manufacturing level, and in distribution to wholesalers and distributors of questionable integrity.

By various loopholes laymen purchase prescription drugs outside of legitimate channels and with a physician's prescription. For example: drug manufacturers may feel privileged to sell drugs to industrial plants without orders from the physician or licensed pharmacist. The claim is made that the drugs are for the industrial health department or the medical director. A registered nurse may order prescription drugs, pretending they are for the physician employing her. Purchase orders are made by research workers (who are neither physicians nor pharmacists) who pretend they are for the laboratory or for experimental animals. Some wholesale drug firms with no professional employees have their orders honored by certain manufacturers. Detail men representing certain pharmaceutical firms, though legal agents but not pharmacists, have dangerous drugs entrusted to them, but it is impossible to determine whether these drugs are properly or improperly disposed of. Physicians' samples may be handed out to some friend by a company's representative, by a doctor's secretary or other office employee—even by the cleaning woman or janitor.

The entire chain of drug distribution should be carefully controlled and restricted to professionally trained individuals who understand what they are doing and are legally responsible for their acts—with no over-the-counter sale of prescription drugs by retail pharmacists, nor given away by those with no professional knowledge. Unless manufacturers institute rigid controls quickly, they may be restricted by federal legislation like the retail pharmacist. They must make certain that prescription drugs are sold only to persons privileged by law to dispense them.

New Growths

Pigmented Nevi, Benign Juvenile Melanoma and Circumscribed Precancerous Melanosis, Sulzberger, M. B., Kopf, A. W., and Witten, V. H. Postgrad. Med. 26: 617-31, 1959.

The clinician should endeavor to recognize the benign pigmented nevi within which malignant melanoma is most apt to develop, particularly the precancerous lesions, quite a percentage of which undergo malignant changes. This includes junction nevus, compound nevus with nevus cells in both the dermis and at the junction of epidermis and dermis, and intradermal nevus with nevus cells entirely within the dermis.

As summarized, the modern concepts regarding nevus cell nevi are: (1) Most of them are seen clinically sometime in childhood. (2) A great majority of them contain junctional cells before puberty; after puberty they usually lack nerve cells at the dermoepidermal zone. (3) Many patients "recall" having a mole at the site of origin of malignancy; others observed none. The mole is described as slightly raised or

macular, mottled, and soft. (4) Junction (nevus cell) elements in time tend to undergo maturation, unless located on the palms, soles, genitalia, or mucous membrane. (5) The average adult has 15 or more pigmented nevi. (6) One fourth of all adults are said to have pigmented nevi on the palms and/or soles. (7) The appearance of nevus-cell varies: the color is pink to black; the surface smooth to digitate; the borders well or poorly defined, level with skin or raised, with or without hairs, small to extensive in area. (8) Malignancy is rare in comparison with the great number of nevi. There is a chance of their becoming malignant if in the lower extremities, nail bed, genitalia, or anorectal mucosa, but even in these sites not all require prophylactic removal. (9) The danger signs are a change in color or in distribution of pigment or development of erythema; sudden change in size; change in appearance (scaling, oozing, bleeding, crusting, ulceration, erosion, infection); change in symptoms (pain, numbness, tingling, burning, and especially itching); spread of pigmentation into the surrounding area; development of satellite nodules; occurrence of regional lymphadenopathy. (10) Repeated trauma may play a role in malignancy with transformation of benign nevus-cell nevus, but this theory is not proved.

Treatment is mandatory in cases wherein nevus-cell nevi are undergoing changes or show "activity," particularly during pregnancy, and those showing histologic evidence of "unrest" (precancerous junction nevi). Treatment is generally indicated in those seemingly undergoing malignant transformation (circumscribed precancerous melanomas), and benign juvenile melanoma, occurring usually on the face, but may appear anywhere on the skin. Conservative surgical excision is the correct treatment of juvenile melanoma. Wide surgical excision or lymph node dissection is not indicated. Malignant melanoma causing metastasis and death are rare before puberty.

The melanotic freckle (lentigo maligna) in the precancerous stage is characterized by its changeability, its irregular outline, and its unevenness of color. It may be scaly and surrounded by a mild inflammation. The tumorous stage develops in one to 34 years, an average of 10 years. It occurs between the ages of 18 and 76; average 40 years. They occur anywhere on the skin, three-fourths of them on the face. One third of these lesions become cancerous; the others remain precancerous or may disappear. Unless removal will cause disfigurement, surgical therapy is recommended in the precancerous stage. Some writers prefer thorough electrodessication and curettage, or use of radiation, radium or radon. The growth sometimes recurs. In the tumor stage a malignant melanoma arising in melanotic freckle (except in the face) should be treated like all malignant melanomas.

Treatment of 126 Cases of Malignant Melanoma: Long Term Results, Gumport, S. L., and Meyer, H. L. Ann. Surg. 150: 989-92, 1959.

A five-year or longer follow-up of 126 cases of malignant melanoma treated surgically showed that of 40 patients with node dissection but with nodes found microscopically negative, 43 per cent survived for 5 or more years. Of 45 with node dissection and nodes found microscopically to contain a tumor, only 22 per cent survived for that period. Dissection was not done in 41 patients; 27 per cent of these survived for 5 or more years. Node dissection was not done because (1) the primary tumor was tiny; (2) the patient was of advanced age; (3) the primary tumor was draining into two or more groups of regional nodes, or (4) the patient refused dissection of the regional node. The best results followed removal of lymph nodes that were clinically negative and microscopically free of tumor.

Clinical diagnosis of malignancy and metastases to lymph nodes does not always prove correct. In 45 cases found micro-

scopically positive, 13 had been considered negative clinically; of 40 cases found microscopically negative, 9 had been considered positive clinically.

The authors found the best results are obtained by "performance of total excisional biopsy of the lesion when a biopsy is indicated; removal of regional lymph nodes in continuity with the tumor site whenever feasible; removal of regional lymph nodes as a separate secondary procedure whenever continuity removal is not feasible." Thus, regional node dissection should be performed whenever feasible, irrespective of the clinical examination of the lymph node regions.

The Management of Melanomas, Scanlon, E. F. Indust. Med. & Surg. 28: 447-49, 1949.

Melanomas in children are unpigmented, and usually undetected. These growths when occurring early almost always show junctional changes. Not all nevi can be removed, but those on the soles, palms and genitalia and those subject to chronic irritation are most likely to undergo malignant degeneration and removal seems advisable. Clinical manifestations may be intermittent mild itching or stinging. Sudden growth and bleeding are late signs. Pigmentation changes do not necessarily indicate malignant degeneration, but immediate removal is advised. Removal of nevi by excision or by use of sclerosing solutions, carbon dioxide, or irradiation is the treatment of choice—not cautery. Small lesions in which malignancy seems doubtful may be treated as benign, but a large lesion demands biopsy, taking the specimen from the center.

A wide area with 2 to 3 cm. of normal tissue on all sides should be incised, even if a skin graft is necessary afterward. Regional lymph nodes are removed with the primary tumor, if practicable, unless the melanoma is distant from the node-bearing area, and the lymph node apparently not clinically involved. If a disconnected node is dissected with the primary tumor, metastatic implants may develop along the intervening lymphatics (satellitosis). The author recommends node dissection in cases where it is easily done as an *en bloc* procedure. A regional node dissection is done as a separate procedure, but at the same time if the nodes are positive but distant from the primary tumor. If satellitosis occurs, which is rarely, disarticulation of the extremity is the only safe procedure.

Melanoma is radio-resistant, but some small lesions can be sterilized by high doses of irradiation and in the cases where surgery is impracticable or is refused. Prognosis following treatment depends upon the patient's age, site of the primary tumor, its nature, and its biological age. Metastasis rarely occurs before puberty, so that excision in children is usually successful. Prepubertal melanomas have occurred in children 10 years old or older; these children chemically were adults. Suspicious nevi should be removed as soon as the child will cooperate under local anesthesia —usually no later than at 5 or 6 years of age.

Some of these tumors grow slowly, some rapidly. Some metastasize before clinical recognition. Some remain localized until very large; some are dormant for years, then suddenly show wild growth. When regional nodes are involved, 10 to 15 per cent of the patients have a 5-year survival rate. If the tumor is confined to a local area, 40 per cent of the patients survive for 5 years. In a few cases the prognosis has been very good where the nevus proved microscopically to be a melanoma. If possible, treatment of lesions resembling nevi should be local excision.

Give to the world the best that you have and the best will come back to you.
—Author unknown

Organization News

Secretaries of local, state, regional, affiliated, subsidiary and other related organizations are invited to submit copy for these columns.

New York

A special award "In recognition of its leadership in the field of foot care protection for children and its educational campaigns to emphasize the importance of foot health, the *Reader's Digest* Public Service Award is presented to the Podiatry Society of the State of New York" was presented by Mr. John Allen, *Reader's Digest* Editor, to Dr. Milton Werbel, President of the New York Society.

In addition to this presentation, a check was given by the *Reader's Digest* to the New York Society to assist in the educational work which has been part of the Podiatry Society's contributions to community foot health.

The award was made at a press luncheon at which a nationwide program for foot examinations of all school children at least once a year was launched, jointly sponsored by the *Reader's Digest* and the New York Society. This was the outgrowth of the publication of an article, "Mind Your Own Two Feet" which appeared in the March issue of *Reader's Digest* condensed from the March issue of the American Medical Association's publication, *Today's Health*. Basic materials for the article had been provided the author by Dr. Mullens, Vice President of the American Podiatry Association and Dr. Benjamin Kauth of New York City (author of "Walk and Be Happy").

Mr. Hollander, Executive Secretary of the New York Society, worked closely with the editors of *Reader's Digest* in advance of publication of the article and chaired the press luncheon. Among the guests at the luncheon was Dr. Shane MacCarthy who has headed the President's Youth Fitness Council since its inception in 1954. Dr. MacCarthy endorsed the program, stating, "much can be done to improve foot health through such a nationwide program of foot examinations for school children as recommended."

"LIFE'S FOUNDATION — YOUR BABY'S FEET" is an outstanding and comprehensive booklet on the growth and care of children's feet. Written for the layman, it is concise, cleverly illustrated and will prove valuable especially to the parents of young children. Many Podiatrists-Chiropodists have received a copy of this booklet and have ordered them in quantity. For those of you who have not ordered and for those who wish to reorder, please clip the order blank below and mail with your check for your supply.

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The program was outlined by Dr. Mullens citing the alarming incidence of foot problems suffered by school children and he said that, "it is clear this tragic problem can best be solved by initiating adequate foot health programs in the schools of America."

Ohio

The Northeast Ohio Academy of Chiropody presented an all-day symposium on geriatrics on March 5th. Joseph I. Goodman, M.D., was presented a plaque for his outstanding work on the foot of the diabetic.

Program of the symposium was: "The Management of Foot Lesions in Diabetes Mellitus" by Joseph I. Goodman, M.D.; "Geriatrics Nutrition" by Sister M. Brigid, C.S.A.; "Problems and Goals in Chronic Illness" by Belden D. Goldman, M.D.; "Scope of Chiropody Practice in Chronic Disease and Geriatrics" and "The Home Care Program of the Visiting Nurses Association" by Henry Dennis, D.S.C.; "The Degenerative Diseases in the Geriatric Patient —Evaluation and Treatment" by Harvey Post, M.D., and "The Geriatric Patient in the Hospital" by Michael Grobsmith.

Pennsylvania

At a joint meeting of the North Philadelphia and Delaware County Chiropody Societies, Dr. James C. Giuffre, Medical Director and Chief of Surgery at St. Luke's and Children's Medical Center, received an honorary membership in the American Podiatry Association. Dr. Giuffre was cited for his many contributions to the profession. He is Dean of the newly organized Philadelphia College of Chiropody.

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Northwestern Division

The February meeting of the Northwestern Division was held February 19 in the Elks Club at Franklin. Dr. Quinton Crawford presided. Following the business meeting, Dr. Leo Lacey, scientific chairman, presented a program in the form of a round-table discussion on insurance forms, income tax problems and general practice hints. Each of the members was called upon to give his personal experiences and suggestions that might be helpful to other members.

Tennessee

The Annual Meeting of the Tennessee Chiropody Association was held on February 25, 26, in Nashville. Dues were increased to $35.00 per year. The Association will meet semi-annually in the future, in addition to the meeting held at the zone convention.

Officers elected for the following year were: President, Dr. Donald Skwor of Memphis; President-elect, Dr. William J. Thomas

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References:
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5. Teichmann, W. O. and Horwath, P. N.: Southern Medical Journal **50,** 1521 (1957).
6. Hoffman, H. L. (Washington, D. C.): Personal communication.

SALEM PHARMACEUTICALS **Naugatuck, Connecticut**

of Memphis; Dr. Ronald Fields will serve as Secretary-Treasurer for another year.

California Podiatry College

On February 28, Dr. Nelson, Dean of the California College of Podiatry, was advised by the Western College Association that it had been granted a "period of initial accreditation as a Specialized Institution. . . . This action was taken upon the advice and recommendation of the Commission on Membership and Standards."

This is a first of our schools to achieve independent accreditation in a regional university and college accrediting association.

Academy of Podiatry

At the 367th meeting of the Academy, Dr. Benjamin Brody gave an illustrated lecture (150 color slides) on "Ingrown Nail Surgery." Drs. Irving Furie and Herbert Rausher presented a plastic flap procedure for ingrown nail cases.

The following presentations will be made at coming meetings: "A New Approach to Practical Podiatry Orthopedics" by Drs. Murray Brombert and Joseph Cinzio, in March; "Nail Wiring Technique" by Dr. Harold Nehleber and "Vitamin Therapy in Foot Pathology" by Drs. Lewis F. Schreiber and Allen Feigenbaum in April; "Modalities of Diabetes Onset and Methods of Management" by Dr. Harold Zarowitz in May.

American College of Foot Orthopedists

The American College of Foot Orthopedists is presently organizing courses in advanced study of podiatry orthopedics. These courses will be given in centrally located areas with convenient attendance periods. Certificates will be issued at the completion of the course of study. All interested parties of the American Podiatry Association should inquire immediately by writing to Dr. Joseph R. Cinzio, 242 Lexington Ave., Passaic, N. J.

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Musebeck Foundation

The terms of the will of the late G. E. Musebeck have provided for the establishment of the G. E. Musebeck Foundation. This is a non-profit organization for the purpose of furthering programs and projects in the field of education and research with respect to shoes and feet.

Mr. Musebeck died December 27th after a short illness at his home in Oconomowoc, Wisconsin. He spent 50 years in the shoe business, working in the East and then coming to the Midwest where he was Vice-President of the Edmonds Shoe Company of Milwaukee, Wisconsin, to the time he started his own shoe company in Danville, Illinois in 1928. Since that time the company has been the manufacturer of the Foot-so-Port shoe line, formerly Health Spot.

Through the many years of his career, Mr. Musebeck worked with the podiatry-chiropody profession in many ways to promote a closer understanding in the relationship between the shoe and the professional man. For the past few years, he was known for his connection with the grant made to the American Foot Health Foundation, and more recently for the production of the film strip, "Little Johnny Sorefoot," through a grant-in-aid by the Musebeck Shoe Company.

While being a rugged individualist in his own way, Mr. Musebeck had a high regard for the importance of the podiatry-chiropody profession and the great service they were, and are, destined to provide for the foot health of the public.

Many members of the profession have heard him express that there should be within the shoe industry, and with the cooperation of the profession, some central research agency that could devote itself to the study of foot and shoe problems and provide the necessary information that is available in other industries through research.

The G. E. Musebeck Foundation represents a start in this direction. This is a non-profit foundation, established through

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holdings of Mr. Musebeck's stock and to be supported from contributions from individuals, dealers, other organizations of any type. Donations from this Foundation will be made for many things concerning foot and shoe research. To schools, to individuals for certain projects, to organizations providing care for those who need help with feet or shoes and many other things. Some of the first grants to be made through this organization will be to the podiatry-chiropody profession in one form or another.

The Chairman of the Foundation is W. W. Gallaher, President of the Foot-so-Port Shoe Company, with four other trustees, consisting of Mr. Willard Andrews, Mr. John Boehm, Mr. George Howie and Judge John Spivey.

Mr. Musebeck was born in Naples, New York. At the age of 15, he started in the shoe business, working in several shoe manufacturing plants in the East and shoemaking centers of Rochester, New York. He then moved to the Midwest where he continued his career in shoemaking in the Wisconsin and Illinois area. He was employed by the United Shoe Machinery Corporation for several years and was later Vice-President and General Manager of the Edmonds Shoe Company of Milwaukee, Wisconsin. In 1927, Mr. Musebeck started his own factory at Danville, Illinois, making the former Health Spot Shoe. In 1946, plants, factories and offices were moved to Wisconsin with the main office located at Oconomowoc where Mr. Musebeck made his home until the time of his death December 27, 1960.

Labor Leaders Honored

Dr. John J. McCaffrey, President of the F.P.A., presented plaques on behalf of the A.P.A.-N.A.C. to labor leaders, Mr. William Steinberg, President of American Radio Association, and Mr. Charles Feinstein of the Luggage Workers Union, in recognition of their contributions to health plans and programs for their members. The occasion was the recent opening of the first Four Freedoms Hotel in Miami Beach, Florida.

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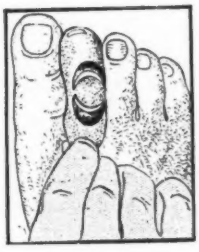

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Communication

To the Editor:

I am writing in connection with the article entitled "Some Experiments Involving Modifications of Fungus Culture Media" by Nancy Lu Conrad, D.S.C., which appeared in the February 1961 issue of the Journal. The experiments done by Dr. Conrad were interesting. It is my feeling, however, that the podiatrist reading this article will throw up his hands at the idea of having to prepare or work out elaborate culture media in order to do mycological culture growths in his office.

For a number of years a well accepted and standardized culture medium has been readily available and is in steady use with regularly predictable results for the growth of the more common pathogenic dermatophytes found on the feet and including the toenails. This consists of a fortified Sabouraud's medium. The fortifying agents are standardized amounts of penicillin, streptomycin, and cyclohexamide. This combination of antibiotics discourages the growth of the non-pathogenic fungi and almost completely eliminates the growth of bacteria. The growth of the pathogens on this material at room temperature is excellent and not at all difficult.

It is true that it does take two or three days for the Candida group to grow out and one to two weeks for the Trichophyton group to grow out. This is simply in the nature of the "beast" and little can be done to speed up the rate of growth of these organisms. However, the direct microscopic examination does give an immediate answer as to whether a fungus organism is present in the skin scrapings and nail clippings, and is positive in a definitely higher percentage of cases than is the culture method by itself.

H. C. Goldberg, M.D.
Plainfield, N. J.

A pedometer worn by Mrs. Blossom G. Jaffray, ARC Gray Lady at Letterman General Hospital in San Francisco, revealed that she walked a mile each hour she was on duty.

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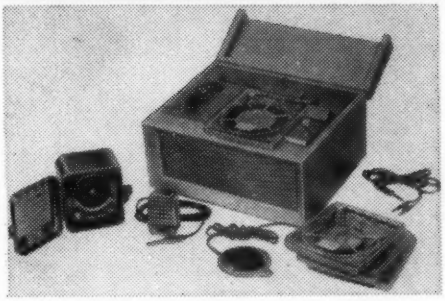

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Peekskill, New York

Saul M. Slomsky
Brooklyn 1, New York

Henry L. Trickey
Melrose, Mass.

Women's Auxiliary Message

Miami Bound

It may seem a little early to you to be thinking about the forthcoming National A.P.A. Convention, but really August will be here before we realize it.

The ladies in Florida have been hard at work for quite some time formulating plans to keep your wife busy and happy while you attend the Scientific Sessions. There will be luncheons, a boat trip to Viscaya, a water show and dance at poolside and many more interesting events.

Plan now to take your wife and family to Miami in August.

Mrs. Cleotha Parham, President

troubled toes! . . . give them a chance to breathe . . .

Baltor Bracelet, 3800 Poplar Ave., Brooklyn 24, N. Y.

Dates to Remember

EVENTS

Youth Fitness Week
April 30-May 6, 1961. Sponsored by President's Council on Youth Fitness.

Foot Health Week
May 14-20, 1961. Sponsored by American Foot Health Foundation.

Youth Foot Care Week
Oct. 15-21, 1961. Sponsored by American Foot Health Foundation.

MEETINGS

American Podiatry Association
Miami Beach, Fla., Aug. 24-29, 1961
Americana Hotel
Seward P. Nyman, Convention Manager
3301 16th St., N.W., Washington 10, D. C.
Michael I. O'Connor, Exhibit Manager
428 E. Preston St., Baltimore 2, Md.

Region One
(Conn., Maine, Mass., N. H., R. I., Vt.)
Dr. Edward H. Buchbinder
10 Allyn St., Hartford, Conn.

Region Two
(New York)
Mr. Gilbert Hollander, Ex. Sec.
353 W. 57th St., New York, N. Y.

Region Three
(Del., Md., N. J., Pa.)
Atlantic City, N. J., Apr. 27-30, 1961
Ambassador Hotel
Dr. B. C. Egerter, Gen. Chairman
507 Liberty Ave., Pittsburgh, Pa.

Region Four
(Ohio)
Columbus, Ohio, May 18-20, 1961
Deshler-Hilton Hotel
J. Edwin Farmer, Ex. Sec.
Fifty W. Broad St., Columbus, Ohio

Region Five
(Ill., Ind., Mich., Wis.)
Dr. W. D. Canada, Pres.
1812 Nichol Ave.
Anderson, Ind.

Region Six
(Colo., Iowa, Kan., Minn., Mo., Nebr., N. Dak., S. Dak.)
Des Moines, Iowa, Apr. 7-9, 1961.
Savery Hotel
Drs. Stewart E. Reed and Ralph C. Kirkwood.
425 Kresge Bldg., Des Moines, Iowa

Region Seven
(Idaho, Mont., Ore., Wash., Wyo.)
Portland, Ore., May 5-7, 1961.
Sheraton Hotel
Vance A. McNish, Convention Chairman
1218 Selling Bldg., Portland 5, Ore.

Region Eight
(D. C., N. C., S. C., Va., W. Va.)
Charles Turchin, Chairman
818-18th St., N.W., Washington, D. C.

Region Nine
(Florida)
Clyde R. Huston, Ex. Sec.
5625 Commerce St., Jacksonville, Fla.

Region Ten
(Ala., Ga., Ky., Miss., Tenn.)
Birmingham, Ala., Oct. 20-22, 1961
Bankhead Hotel
Dr. Stanley Frank, Secretary
1250 Forrest Ave.
Gadsden, Ala.

Region Eleven
(Ark., La., N. Mex., Okla., Texas)
Fort Worth, Texas, June 14-17, 1961
Hotel Texas
16th Southwestern Chiropody Congress
44th Annual Convention of Texas Society
Dr. Joseph R. Ordile, 111 Professional Bldg., Ft. Worth 4, Tex.

Region Twelve
(Ariz., Cal., Nev., Utah)
San Francisco, Calif., May 24-28, 1961.
Jack Tar Hotel
David Y. Chan
2107 Van Ness Ave., San Francisco, Calif.

International Union of Podology
Second International Congress.
Belgium, France, W. Germany, Holland, Spain, Switzerland, Argentina, Sept. 8-12, 1961.

Attend Your

STATE & REGIONAL MEETINGS

THEN YOUR NATIONAL

Mood Elevators

Contributions to this column are more than welcome. In fact it depends upon them. A.O.P.

Psychiatric treatment:

After many weeks of treatment the doctor told his patient: "You've got to give up smoking."

"Give up smoking! Will that solve my problem?"

"No," replied the psychiatrist, "but it will solve mine. At least you will stop burning holes in my couch."

* * *

Upside down

The year 1961 promises to be a topsy-turvy year. If you don't believe it, turn this page upside down and look at the figures 1961. What do you see? Well, you won't see another freak like this for 4048 years. The last time it occurred was 80 years ago.

* * *

Who says we Americans have no respect for the law? Just let a motorcycle cop slide out from behind a hedge and see for yourself.

* * *

And in line with that last crack, a traffic cop warned a pedestrian to walk more carefully and avoid that run-down feeling.

DR. POD By Bob Hughes

"Oh well now, doctor, that is interesting. Just what is this emergency out at the country club?"

A bit of gossip:

As the X-ray specialist walked down the aisle with his fiancee, who had been a patient, a woman whispered to her friend, "I wonder what he saw in her."

* * *

You are so right

Boss, to a chronic clock watcher: "You can learn something by watching that clock. It passes its time by keeping its hands busy."

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Awards for Research Papers

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for Research in Podiatry-Chiropody for 1961

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Seventeenth Year of Awards
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Application forms, rules and regulations can be obtained from the Secretary. The final date on which papers will be accepted is May 1, 1961.

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May 14-20, 1961

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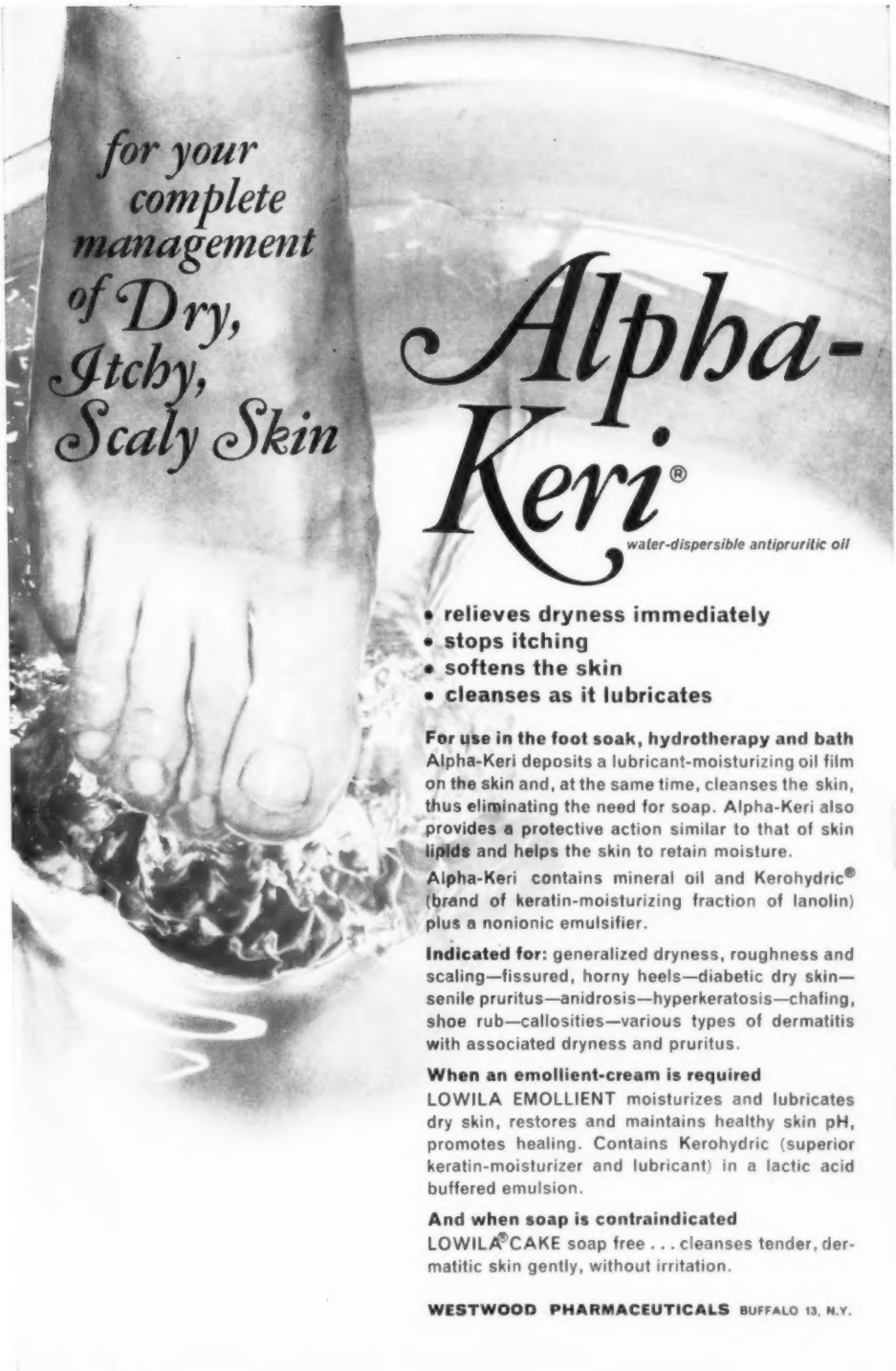

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For use in the foot soak, hydrotherapy and bath
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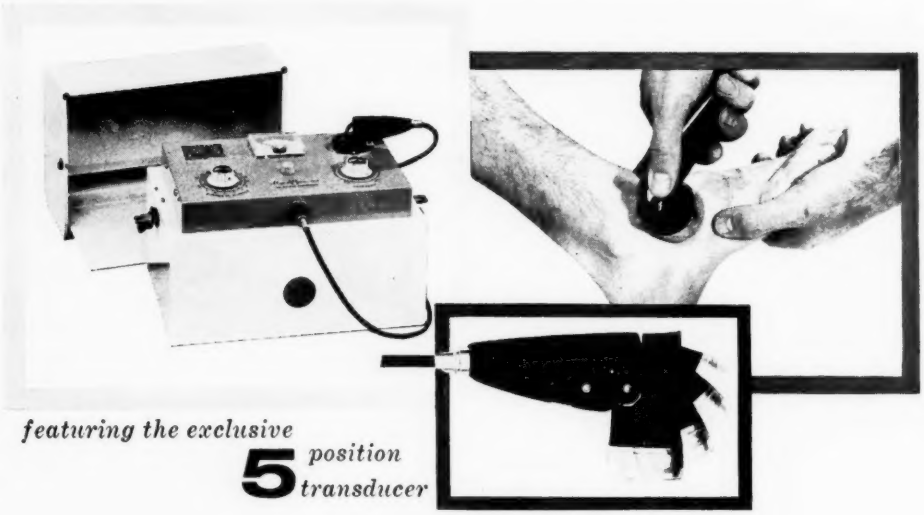

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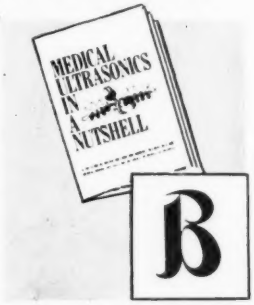
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